

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2010
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
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F 282	<p>Continued From page 22</p> <p>A nurse's note, dated 07/10/10 at 9:30 PM, revealed Resident #16 was wandering in other residents' rooms and made the statement, "I want some pussy, go ask her to give me some pussy" and then called the staff "Sluts", when redirected. Review of the care plan revealed no new interventions were implemented at this time.</p> <p>Documentation on a nurse's note, dated 07/12/10 at 9:30 AM, revealed "Resident noted in 212 A, female-bed, masturbating and ejaculated on bed; 212 A resident not in room". Review of the care plan revealed no new interventions were implemented at this time.</p> <p>On 07/15/10 at 10:40 AM, a nurse's note entry revealed the resident had "Pants down fondling self" and was in full view of the roommate. The nurse's note revealed Resident #16 stated all the female staff were "Whores". Review of the care plan revealed the facility added an intervention to monitor every 15 minutes, placed an alarm at the top of the resident's door and pharmacy reviewed Resident #16's medications. The pharmacy review recommended hormone therapy and an increase in Aricept. Furthermore, there was no documented evidence the 15 minutes checks were implemented and completed by staff on 07/15/10.</p> <p>Nurse's note, dated 07/19/10 at 8:30 AM, revealed Resident #16 was found in another resident's bed and when redirected by the staff, he/she became aggressive and slapped at them. There continued to be no documented evidence the 15 minutes checks were implemented and completed by staff on 07/19/10. Further review revealed, the physician increased the Aricept from 5 milligrams (mg) to 10 mg on 07/20/10.</p>	F 282	<p>F282 (continued)</p> <p>Review of the 24 hour nursing reports will be conducted daily, by the Director of Nursing or Unit Managers in her absence, to identify the onset of or changes in, behaviors that are sexually inappropriate. On weekends and holidays the on call nurse will verbally review the 24 hour reports by phone to identify a new onset of sexually inappropriate behaviors. If sexually inappropriate behaviors are identified, the on call nurse will come in to review interventions implemented and to determine if additional interventions are indicated and report findings to the Director of Nursing and / or Administrator. The care plan will be reviewed by the DON or the specified Unit Manager to verify that the planned interventions were implemented.</p> <p><u>How will the corrective actions be monitored to ensure the deficient practice will not recur:</u> Unit managers will randomly select four residents (11.2%) from each unit weekly who require more than one person for assistance with transfers. Without prior notification, staff providing care for these residents will be observed conducting transfers to validate compliance with the Nurse Aide Data Sheet. The observations will be conducted weekly for 8 weeks then monthly x3 months. If concerns are identified, re-training /discipline will result. The Committee will review findings and if no deviations in observations are identified, then the observations may be reduced in number or frequency. Conversely, if deviations are noted then the number of observations will increase in number or frequency.</p> <p>The orders and 24 hour report records and the care plans for residents identified with</p>	

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F 282	<p>Continued From page 23</p> <p>On 07/22/10, per the nurse's note at 3:20 PM, Resident #16 was observed pulling the cover off a female resident and told staff he/she was "Up to meanness". Additionally, that same day, an interview with Housekeeping Staff #1, on 08/18/10 at approximately 11:45 AM, revealed she observed Resident #16 in Resident #14's room on 07/22/10. Resident #16 was standing over Resident #14 who was in bed, and Resident #16's hand was inside the pants of Resident #14 rubbing his/her pubic area. Furthermore, an interview with family member #1 (on 08/20/10 at 4:00 PM, former resident of the facility) revealed on 07/22/10 he/she had witnessed Resident #16 rubbing Resident #7's leg and then moved his/her hand and began rubbing Resident #7's pubic area. Resident #7 was half asleep on the couch and did not know what was happening. The family member stated, "It made me feel bad".</p> <p>The facility was unable to provide any documented evidence the 15 minute monitoring of Resident #16 was implemented. While the pharmacy review recommended hormone therapy and an increase in Aricept, the Aricept order was not received until 07/20/10. The hormone therapy was not initiated until 07/23/10, the day after the incident with Residents #14 and #7. Furthermore, the facility was unable to provide evidence interventions were re-evaluated for effectiveness.</p> <p>On 08/19/10 at 5:50 PM, an interview was conducted with Nurse Aide (NA) #1. NA #1 revealed Resident #16 wandered and had a favorite room (Resident #14's) and required frequent redirection out of that room. NA #1 stated, "We all tried to watch Resident #16", but was not aware of any process for implementing</p>	F 282	<p>F282 (continued)</p> <p>behaviors will be reviewed in the next days Abbreviated Quality Assurance meeting by the DON, or the MDS Coordinator, in her absence to verify that the plan was updated and reflects interventions necessary to protect the safety and well being of other residents. If sexually inappropriate behaviors occur on the weekend, the care plan will be reviewed in the next weekday AQA meeting to verify that appropriate updates were made.</p> <p>Care Plan revisions are not limited to this process and can be made at anytime that it is noted that a revision is indicated. When new interventions are added for a resident who exhibits sexually inappropriate behaviors, the resident and the intervention change will be added to the 24 hour report, to monitor the effectiveness of the interventions. The resident will remain on the 24 hour report for at least seven days. If interventions are noted to be ineffective, the care plan will be revised with appropriate interventions and will be ongoing unless modified at the recommendation of the Quality Assurance Committee.</p>	

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F 282	<p>Continued From page 24 every 15 minute monitoring.</p> <p>On 08/20/10 at 9:45 AM, an interview conducted with LPN #2 revealed Resident #16 entered other residents' rooms several times and Resident #16 waited for one resident to leave a room, leaving the other resident alone. Resident #16 knew what he/she was doing and at no time did she see him/her confused. Resident #16 entered another resident's (#18) room one night demanding sex and scared him/her. LPN #2 stated Resident #16 did not bother male residents and said, "He/she made me feel uneasy".</p> <p>An interview conducted with LPN #1, on 08/20/10 at approximately 8:30 AM, revealed Resident #16 had behaviors of staring at everybody's bottoms and entering other residents' rooms. LPN #1 stated she thought Resident #16 had a purpose for entering some rooms in particular and thought he/she "prayed on female residents". The facility placed a door alarm on Resident #16's door because he/she had been in other residents' rooms touching him/herself, but it was not effective if Resident #16 was not in his/her room. LPN #1 stated she wasn't sure if Resident #16 was or was not on 15 minute checks but "in 15 minutes Resident #16 could do what he/she did to Resident #14". Additionally, the LPN did not know if there was a policy or procedure for 15 minute monitoring. LPN #1 stated, "I was scared of this guy myself" and had told the administrative staff at the morning meeting when the door alarm was implemented 07/15/10.</p> <p>An interview with the Social Services Director (SSD), on 08/20/10 at 11:45 AM, revealed she was responsible to update the behavior care plan when residents had behaviors but she had not</p>	F 282			

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F 282	<p>Continued From page 25</p> <p>implemented any new interventions for Resident #16.</p> <p>Interviews with LPN #2 on 08/20/10 at 8:30 AM, LPN #1 on 08/20/10 at 9:45 AM, the SSD on 08/20/10 at 11:45 AM, and CNA #3 on 08/20/10 at 3:10 PM, revealed they thought Resident #16 had been on 15 minute checks off and on but no particular staff had been assigned as responsible to ensure the checks were completed and no flow sheet was utilized to verify if checks were completed. Additionally, the staff interviewed were not sure if 15 minute checks were on Resident #16's care plan. A review of the Nurse Aide Data Sheet (not dated) revealed two assist with all care and door alarm for a safety device. The Behavior Interventions sections was blank. The care plan titled "Behavioral symptoms revealed 15 minute checks, dated 07/10/10 that the DON had stated she actually placed on the care plan on 07/15/10. Additionally, the DON stated she was not sure if 15 minute checks had been put on the Nurse Aide Data Sheet. No other documentation for 15 minute checks could be verified.</p> <p>An interview on 08/20/10 at 12:20 PM, with the Director of Nursing (DON), revealed nurses were responsible to ensure a resident's care plan was updated if an immediate intervention was needed. She thought Resident #16 had been on 15 minute checks but on 07/15/10 she had added "to be monitored every 15 minutes" with a date of 07/11/10. Additionally, on 07/15/10, "alarm to top of door" and "pharmacist reviewed meds" was added.</p> <p>An Interview with the Administrator conducted 08/19/10 at approximately 6:35 PM, revealed</p>	F 282			

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F 282	<p>Continued From page 26</p> <p>Resident #16 had been placed on 1:1 observation, after 07/22/10, when he/she was observed by staff with his/her hand in the front of Resident #14's pants. The Administrator stated the facility had previously initiated 15 minute checks due to Resident #16's inappropriate behaviors; however, there was no documented evidence that the checks were completed. The Administrator further revealed the facility had not developed a policy and procedure for 15 minute monitoring. Resident #16's behaviors had been discussed in the morning meetings and staff were told to present reality and that his/her behaviors were unacceptable.</p> <p>An acceptable Allegation of Compliance (AoC) was received 09/02/10. The actions taken to verify the removal of Immediate Jeopardy included a policy developed regarding Inappropriate Sexual Behavior Management on 08/30/10. The Administrator and staff were trained regarding this policy beginning on 08/30/10 and continuing with on-coming employees before they began work. A review of the Abuse Policy with an emphasis placed on recognizing sexual abuse and inappropriate behaviors and the need to report any suspected abuse of any kind was reviewed. A policy was developed on 08/30/10 describing the process to be followed when providing behavior monitoring including 1:1 monitoring and every 15 minute monitoring. Review of the 24 hour Nursing reports will be conducted daily, by the Director of Nursing or Unit Managers in her absence, to identify the onset of or changes in, behaviors that are sexually inappropriate. On weekends and holidays the on call nurse would verbally review the 24 hour reports by phone to identify a new onset of sexually inappropriate behaviors. If</p>	F 282		

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F 282	<p>Continued From page 27</p> <p>sexually inappropriate behaviors are identified, the on call nurse would come in to review interventions and report to the Director of Nursing (DON) and/or Administrator. Additional interventions would be based on the assessment of contributing/causative factors. A post test was given to the Administrator and staff to verify understanding. The Care Plan team including the DON, MDS Coordinator, Unit Managers, Social Service Director, Activity Director, Dietary Director, Rehab Director and the Administrator, were provided training regarding updating the plan of care as conditions arise and monitoring the effectiveness of the approaches that were in place. The training was conducted by Quality Management Specialist Nurses on 08/31/10.</p> <p>The new Sexual Behavior Management policy, dated 08/30/10, was reviewed on 08/31/10. The Administrator, SSD and staff were trained regarding this policy beginning 08/30/10. The Administrator and SSD were trained by the Quality Management Specialist Nurses on 08/30/10 and continued with on-coming employees before they began work and post tests were completed. The sign in sheets and post tests were verified and interviews conducted with the Administrator, SSD and staff on 09/01/10 and 09/02/10 verified their understanding. A new policy dated 08/30/10 for the process to be followed for every 15 minute monitoring was reviewed 09/01/10 and the Administrator, SSD and staff were able to verify understanding through interviews conducted 09/01/10 through 09/02/10. The Care Plan team including the Administrator, DON, MDS Coordinator, Unit Managers, SSD, Activity Director, Dietary Director and the Rehab Director were provided training regarding updating the plan of care as conditions</p>	F 282			

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F 282	<p>Continued From page 28</p> <p>arise and monitoring the effectiveness of the approaches that were in place. The training was verified conducted by Quality Management Specialist Nurses on 08/31/10.</p> <p>The Immediate Jeopardy was verified removed on 09/02/10, as alleged in the AoC, with the scope/severity lowered to a "D", based on the facility's need to continue to evaluate the implementation of systematic changes.</p> <p>2. Record review revealed Resident #5 was admitted to the facility on 01/26/10, with a diagnosis of Left Effected Cerebrovascular Disease.</p> <p>A review of the Mlinimum Data Set (MDS) assessment, dated 02/08/10, revealed the facility identified Resident #5 as moderately cognitively impaired and required extensive assistance of two or more staff for transfers.</p> <p>A review of the Comprehensive Care Plan, dated 02/07/10, revealed interventions included extensive assistance of two staff with transfers. Further review of the Nurse Aide Data Sheet, dated 04/08/10 through 08/13/10, identified the resident as non-ambulatory, at risk for falls, two staff assist at times for mobility, and two staff assist for transferring.</p> <p>An interview, on 08/19/10 at 10:50 AM, with Certified Nurse-Aide (CNA) #1 revealed she was aware Resident #5 required extensive assist of two staff for transfers.</p> <p>An interview, on 08/19/10 at 10:55 AM, with CNA</p>	F 282		

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F 282	<p>Continued From page 29</p> <p>#2 revealed she was aware. Resident #5 was care planned for two staff assist with toileting and transfers. She revealed on occasion she transferred him/her alone. She stated, "He does pretty good with grabbing hold of something to help with the transfer".</p> <p>An interview, on 08/19/10 at 11:30 AM, with Licensed Practical Nurse (LPN)/MDS #3 revealed Resident #5 had always been assessed as in need of two assist for transfers and the CNA transferring him/her at the time of the fall on 07/03/10, "did not follow the CNA care plan".</p> <p>A telephone interview, on 08/20/10 at 9:40 AM, with CNA #3 revealed on 07/03/10 she was attempting to transfer Resident #5 alone to bed from the resident's wheelchair when the resident began to slide. She eased the resident to the floor. She stated she was aware the resident was care planned for two staff assist with transferring; however, she did not get help.</p> <p>An interview, on 08/20/10 at 7:05 PM, with LPN #4, the unit nurse on 07/03/10, revealed she was called into Resident #5's room by CNA #3. She observed Resident #5 on the floor. She assisted CNA #3 to assist the resident off the floor and to bed. She stated the resident was care planned on that date for two staff assist but CNA #3 did not seek assistance before attempting to transfer the resident alone.</p> <p>An interview, on 08/20/10 at 10:55 AM, with LPN #5, Unit Manager for the unit on which Resident #5 resided, revealed there had been no changes made to the care plan related to transfers. She stated on 07/03/10, Resident #5 required extensive assistance of two staff for transfers.</p>	F 282		
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F 282	Continued From page 30	F 282		
F 323 SS=D	<p>An Interview, on 08/20/10 at 11:05 AM, with CNA Manager #4 revealed orientation of new CNAs to Nurse Aide Data Sheets included review of the forms and explanation of each area addressed on the forms. New employees were instructed to review the forms daily for changes or updates and to follow the care plans for care of the residents.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to prevent falls for one resident (#5) in the selected sample of 20. Resident #5 required assistance of two staff for transfers. On 07/03/10 a Certified Nurse Aide (CNA) attempted to assist the resident without the assistance of a second staff, which resulted in a fall.</p> <p>The findings include: Resident (#5) was admitted to the facility on 01/26/10, with a diagnosis of Left Effected Cerebrovascular Disease.</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 02/08/10, revealed the facility</p>	F 323	<p>483.25(h) Free of Accident Hazards/Supervision It is the facility's routine practice to maintain the facility in a manner that the resident environment remains as free of hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.</p> <p><u>Corrective Measures for Resident Identified in the deficiency.</u> Resident #5 will be transferred utilizing two staff members in accordance with the resident's plan of care. CNA #3 was re-educated by the DON on 9/1/10 and verbalized understanding. CNAs working on Resident #5's unit on 07/03/10 will be re-trained by nurse unit managers and required to give return demonstration to validate following the Nurse's Aid Data Sheet as required. This training will start on 09/07/10 and will be completed by 09/10/10.</p> <p><u>How other residents who may have been affected by this practice were identified:</u> Transfer requirements on the Nurse Aide Data Sheets were reviewed by the Nursing Unit Managers and Care Plan Coordinator. The review was completed on 9/7/10. The findings of the review revealed that 22 residents on 100 hall and 21 residents on 200 hall required more than one person to assist with transfers. The CNAs who provide care for the residents identified as needing more than 1 person for transfers, were interviewed by the Unit Managers and CNA Manager to verify that they understood the requirement to follow the nurse aide data sheet, without deviation. These interviews were completed on 9/9/10. All C.N.A.s interviewed correctly identified the required amount of assistance and validated that they understood that the Nurse Aide Data Sheet was to be followed, with no one being unaware of the required assistance.</p>	09/11/2010

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F 323	<p>Continued From page 31</p> <p>Identified Resident (#5) as moderately cognitively impaired, and required extensive assistance of two or more staff for transfers.</p> <p>A review of the Comprehensive Care Plan, dated 02/07/10, revealed interventions included extensive assist of two staff for transfers. Further review of the Nurse Aide Data Sheet (NADS), dated 04/08/10 through 08/13/10, revealed the resident as non-ambulatory, at risk for falls and two staff assistance at all times for mobility and transfers.</p> <p>A telephone interview on 08/20/10 at 9:40 AM with CNA #3 revealed she attempted to transfer Resident (#5) alone from the wheelchair to his/her bed on 07/03/10. When the resident's feet started to slide, she had to ease him/her to the floor. CNA #3 stated she was aware, at the time of the attempted transfer, that the resident was assessed as requiring two staff for transfers. She stated it was documented on the Nurse Aide Data Sheet; however, she did not request help to transfer the resident.</p> <p>An interview on 08/20/10 at 7:50 PM with LPN #4, revealed on 07/03/10, she was assigned to the unit on which Resident (#5) resided. CNA #3 called her to the resident's room. LPN #4 observed the resident on the floor at his/her bedside. She stated CNA #3 informed her that she attempted to transfer the resident without assistance and the resident's feet started to slide. The CNA stated she eased the resident to the floor. LPN #4 revealed she helped CNA #3 to assist Resident #5 off the floor and to bed. The LPN stated Resident #5 was care planned at that time and currently for two staff assistance for transfers.</p>	F 323	<p>F323 (continued)</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Re-education will be initiated on 9/7/10 by Director of Nursing & CNA Manager to re-train all CNAs on following the Nurse Aide Data Sheets for transfer requirements as established by the interdisciplinary care plan team and, emphasizing that no less assistance can be provided by staff than is specified on the nurse aide data sheet. Inservicing will be initiated on 9/7/10 and continued at multiple small group sessions through 9/10/10. The Director of Nursing will be responsible to arrange or provide training for any CNAs who have not completed the training prior to the last scheduled session on 09/10/2010 will be trained before their next shift worked. If concerns are identified retraining /discipline will result. The Committee will review findings and if no deviations in adherence to the care plan for transfers are identified, then the observation of care plan compliance may be reduced in number or frequency. Conversely, if deviations are noted then the number of observed transfers will increase in number or frequency.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u> Unit managers will randomly select four residents (11.2%) from each unit weekly who require more than one person for assistance with transfers. Without prior notification, staff providing care for these residents will be observed conducting transfers to validate compliance with the Nurse Aide Data Sheet. The observations will be conducted weekly for 8 weeks then monthly x3 months. Findings of the observations will be reported to the Director of Nursing, and in her absence, the MDS Coordinator, as well as, to the facility's Quality Assurance Committee. If concerns are identified retraining /discipline will result. The Committee will review findings and if no deviations in observations are identified, then the observations may be reduced in number or frequency. Conversely, if deviations are noted then the number of observations will increase in number or frequency.</p>	
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F 323	Continued From page 32	F 323		
F 490 SS=J	<p>Interviews on 08/19/10 at 10:50 AM and at 11:55 AM and on 08/20/10 at 10:55 AM, with CNA #1, LPN/MDS #3 and LPN #5, Unit Manager, respectively revealed they were all aware Resident #5 required extensive assistance of two staff for transfers and that he/she was care planned for two staff assistance with transfers.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure it was administered in a manner that enabled it to use its' resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Resident #16 displayed sexually aggressive behaviors that affected four (4) residents (#7, #14, #18 and #ZZ), in the selected sample of five and resulted in reported sexual abuse. The facility was aware of Resident #16's behavior and failed to implement effective interventions to manage the sexual behaviors of Resident #16 and provide appropriate supervision to prevent abuse. While the facility implemented interventions to address the resident's behaviors, the facility failed to ensure the interventions were effective, resulting in continued sexual behaviors towards staff and residents and sexual abuse of</p>	F 490	<p>F490 483.75 Effective Administration/Resident Well Being</p> <p>It is the normal practice of Spring View Health and Rehab to administer the facility in a manner that enables the use of its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u> <u>Resident #16</u> was placed on 1:1 monitoring on 7/22/10. He remained on 1:1 monitoring until the Resident #16 was discharged on 7/23/10 to a geriatric psych facility. <u>Resident #7</u> was assessed by nursing staff following the incident. No signs and symptoms of pain or distress were noted as evidenced by the nurses note of 7/22/10. The Social Service Director visited on 7/22/10 at 1000 and recorded that, " due to resident scoring very poorly on cognitive scale and diagnosis of late Alzheimer's interview was ineffective." Resident #7 received follow up visits from Social Services and from the facility Administrator, who has previously been a Social Service Director, on at least eight separate occasions from 7/22/10, until 7/23/10 with notes describing each visit. Her physician visited on 8/31/10 and reported that she observed no ill effects from the encounter.</p>	10/01/2010

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F 490	Continued From page 33 Residents #7 and #14. Therefore, the facility failed to ensure residents were free from abuse. It was identified that the facility's failure to intervene to prevent abuse placed residents at risk for serious injury, harm, impairment, or death to a resident receiving care in this facility. The findings include: Refer to F223 Based on observations, interviews and record reviews, it was determined the facility failed to ensure each resident had the right to be free from mental, physical and sexual abuse. The facility failed to assess and implement effective interventions to prevent sexual abuse for four residents (#7, #14, #18 and #ZZ) in the selected sample of five. On 06/09/10, the facility identified Resident #16 as having behaviors of a sexual nature and became aware of Resident #16's history of sexual behaviors in other facilities on 06/15/10. While the facility implemented care plan interventions to address Resident #16's sexually aggressive behaviors, the facility failed to ensure those interventions were effective in managing the resident's behaviors and failed to identify and implement interventions to prevent potential abuse of other residents. Resident #16 began having sexually aggressive behaviors which impacted other residents of the facility on 07/10/10, and continued on 07/12/10, 07/15/10, 07/19/10 and 07/22/10. Furthermore, the facility while aware of these incidents, failed to ensure interventions implemented were effective in managing Resident #16's repetitive sexual behaviors and failed to provide appropriate supervision to prevent Resident #16 from abusing residents in the facility. Resident #16 touched	F 490	F490 (continued) <u>Resident #14</u> was assessed following incident, had fever of 99.2, but was currently receiving treatment for UTI. Social Service Director visited with resident on 7/22/10 following incident and visited twice again on 7/23/10 to follow up and observe for signs or symptoms of distress. Her visits and observations were recorded in the Social Service progress notes on 7/22/10 in an untimed entry, and subsequent entries on 7/22/10 at 1545 and 1930, on 7/23/10 at 0830 and 1430. Following the initial entry when she notes that the resident was "upset," each of the subsequent entries states that there were "no visual signs of distress." Interview with the Social Service Director indicates that the "visual signs" that she was looking for were things such as crying, tearfulness, fidgeting, facial expressions, changes in voice from normal. Additionally, the resident voiced that she was "ok." On 7/23/10 resident was transferred to the hospital for an unrelated condition and her return is not anticipated. <u>Resident #18</u> was admitted for short term rehab on 7/9/10 and was discharged on 7/14/10. After receiving the report of the incident, the Social Service Director visited the resident. She stated that the resident exhibited no signs of distress during the visit. During her stay, other than the nurses note on 7/11/10, when she reported the incident, she exhibited no indicators of mood or behavior symptoms. <u>Resident ZZ</u> reported the incident to the Social Service Director during a quality assurance interview on 7/27/10. The Social Service Director followed up with her on 7/28/10, 7/29/10 and again on 8/5/10. Each of these interactions are recorded in the Social Service Progress Notes. The resident voiced no concerns with the situation and exhibited no signs of distress. She was also interviewed by	

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F 490	<p>Continued From page 34</p> <p>Resident #7's pubic area while he/she was sitting on a sofa in the common area of the facility. Resident #16 had his/her hand in Resident #14's pants touching Resident #14's pubic area and Resident #14 was yelling for help. Resident #18 was in bed, during the night, when Resident #16 entered Resident #18's room and demanded sex from Resident #18. Resident #ZZ reported to staff that Resident #16 stood in his/her doorway and demanded sex.</p> <p>Refer to F250 Based on interviews and record reviews, it was determined the facility failed to ensure appropriate and timely social services were provided for two residents (#16 and #18) in the selected sample of 5. The Social Service Director (SSD) failed to promote the general well being of each resident through identification of their emotional and psychosocial needs and failed to ensure effective interventions were developed and implemented when residents exhibited behaviors, which resulted in negative outcomes to the resident or other residents of the facility. On 06/09/10, the facility identified Resident #16 as having behaviors of a sexual nature and became aware of Resident #16's history of sexual behaviors in other facilities on 06/15/10. While the facility implemented care plan interventions to address Resident #16's sexually aggressive behaviors, the facility failed to ensure those interventions were effective in managing the resident's behaviors and protecting other residents within the facility. Resident #16 began having sexually aggressive behaviors which affected other residents of the facility on 07/10/10, and continued on 07/12/10, 07/15/10, 07/19/10, and 07/22/10. The failure to effectively address and manage Resident #16's sexually aggressive</p>	F 490	<p>F490 (continued) the Administrator on 7/28/10. She relayed a similar account of events and stated, "I am a retired Social Worker. I know how to deal with people like that." A subsequent interview was conducted on 8/31/10, to make sure that there were no late effects from the event and the resident stated that she, "was fine and had not thought anything else about it." This resident is alert and oriented to person, place, and time. She is independent in her decision making and is her own clinical decision maker. Staff education was conducted on 8/5/10 regarding Recognizing Abuse and Abuse Reporting as part of a general staff meeting. The abuse portion of the training specifically included sexual abuse and was conducted by the Social Service Director.</p> <p><u>How Other Residents were Identified that may have been impacted by this practice:</u> As part of the Quality Assurance process, the facility attempted to interview 100% of all female residents on 7/27/10 and asked, "Has anyone ever touched you or cared for you in a manner that you felt was inappropriate or made you uncomfortable?" and "Do you feel safe here at this facility?" One of the residents (Resident #ZZ) stated that a male resident, who is no longer here, had said something to her, but she had no physical contact with him. Of the 43 residents that were interviewed, 27 were coded on the MDS as having severely impaired cognitive decision making, however, all but two provided sensible answers to the direct questions. A Resident Council meeting was held on 7/27/10 to review what constituted abuse and how to report it if they were abused or suspected someone else was being abused. This review of recognizing and reporting abuse included sexual abuse. The Resident Council meeting was conducted by the Social Service Director.</p>	

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F 490	Continued From page 35 behaviors resulted in two residents (#7 and #14) being sexually abused by Resident #16. Additionally, the facility failed to ensure the emotional and psychosocial needs of Resident #18 were met after Resident #18 reported Resident #16 entered his/her room during the night and demanded sex. Refer to F282 Based on record review and interviews, it was determined the facility failed to ensure services provided or arranged by the facility by qualified persons in accordance with each resident's written plan of care for one resident (#16) in the selected sample of five. On 06/09/10, the facility identified Resident #16 as having behaviors of a sexual nature and became aware of Resident #16's history of sexual behaviors in other facilities on 06/15/10. While the facility implemented care plan interventions to address Resident #16's sexually aggressive behaviors, the facility failed to ensure those interventions were effective in managing the resident's behaviors and failed to identify and implement interventions to prevent potential abuse of other residents. Resident #16 began having sexually aggressive behaviors which impacted other residents in the facility on 07/10/10, and continued on 07/12/10, 07/15/10, 07/19/10 and 07/22/10. Furthermore, the facility while aware of these incidents, failed to ensure interventions implemented were effective in managing Resident #16's repetitive sexual behaviors and failed to provide appropriate supervision to prevent Resident #16 from abusing residents in the facility. Resident #16 touched Resident #7's pubic area while he/she was sitting on a sofa in the common area of the facility. Resident #16 had his/her hand in Resident #14's pants touching Resident #14's pubic area and	F 490	F490 (continued) Clinical records were reviewed to identify other residents who exhibit behaviors that may suggest that they have the potential to exhibit inappropriate sexual behaviors toward residents in the future. This review was completed using daily tracking records which identify behavior MDS indicators including physical and verbal abuse. The records of these residents were reviewed and the care givers for these residents interviewed to identify if any behaviors were of a sexual nature. None were identified. This review was completed by Quality Management Specialist Nurse, Director of Nursing and Unit Managers. The review was completed on 09/30/10. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The Director of Nursing is responsible for providing or arranging for training for any employee who is not readily available for any training provided for this deficiency. She is maintaining a list of employees requiring inservice. The list is consulted daily to identify anyone scheduled to work in the next 2 days, to assure that training will be provided prior to their return. On Fridays, the list will be reviewed for weekend and Monday staff to identify if any will require training. The Director of Nursing will either provide the training or arrange for an Administrative Nurse or Quality Management Nurse to provide the training prior to the employee returning to duty. A policy regarding Inappropriate Sexual Behavior Management was developed on 8/30/10. The policy contains information defining inappropriate behaviors and sexual abuse, and requirements for staff response.	

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F 490	<p>Continued From page 36</p> <p>Resident #14 was yelling for help. Resident #18 was in bed, during the night, when Resident #16 entered Resident #18's room and demanded sex from Resident #18. Resident #ZZ reported to staff that Resident #16 stood in his/her doorway and demanded sex.</p> <p>A review of a closed record revealed the facility admitted Resident #16 on 08/07/10. On 06/09/10, the facility became aware Resident #16 began exhibiting sexually aggressive behaviors towards staff. On 06/15/10, the facility received documentation, per a History and Physical, which detailed Resident #16 had a history of sexually behaviors at other facilities. While the facility developed a care plan on 06/15/10, the facility was unable to provide documented evidence of interventions that had been implemented to ensure the safety of other residents due to Resident #16's sexually aggressive behaviors. Resident Assessment Protocol (RAP), dated 06/20/10, revealed Resident #16 had moderately impaired cognitive skills for daily decision making and socially inappropriate behaviors. Care plan interventions to notify the Social Services staff when Resident #16's behaviors were exhibited more frequently were unable to be verified through review of documentation. Interview with the SSD, on 08/20/10 at 11:45 AM, revealed she had been made aware of one incident on 07/11/10; however, had not made any changes to the resident's behavior care plan.</p> <p>On 07/11/10, Resident #18 reported to the facility staff the he/she was in bed, during the night, when Resident #16 entered Resident #18's room and demanded sex from Resident #18. Resident #ZZ reported to staff (unable to remember who) that Resident #16 stood in his/her doorway and</p>	F 490	<p>F490 (continued)</p> <p>Staff were trained regarding this policy beginning on 8/30/10 and continuing with oncoming employees before they began work. Training was conducted by Director of Nursing, Quality Management Nurse, MDS Coordinator, and Nursing Supervisors. This education will be continued until all employees have been trained. The Director of Nursing will be responsible to provide training to any employees that are not immediately available for training, prior to their return to duty. The facility administrator was trained regarding the Inappropriate Sexual Behavior Monitoring policy on 8/30/10. She completed the Post test for training on 08/31/2010.</p> <p>The requirement to report any suspected abuse including sexual abuse was reinforced along with a review of the Abuse Policy. Although education was provided regarding the entire abuse policy an emphasis was placed on recognizing sexual abuse and inappropriate behaviors and the need to report any suspected abuse of any kind. This education was initiated on 8/30/10 and continuing with oncoming employees before they began work. Training was conducted by Director of Nursing, Quality Management Nurse, MDS Coordinator, and Nursing Supervisors. This training will be continued until all employees have been educated. The Director of Nursing will be responsible to provide training to any employees that are not immediately available for training, prior to their return to duty, utilizing the previously described process. A policy was developed on 8/30/10 describing the process to be followed when providing behavior monitoring including one to one monitoring and 15 minute monitoring. A record for documenting 15minute monitoring was included with the policy. While</p>		

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F 490	<p>Continued From page 37</p> <p>demanded sex. An interview on 08/20/10 at 4:00 PM with family member #1 revealed he/she observed Resident #16 touch Resident #7's pubic area on 07/22/10, while he/she was sitting on a sofa in the common area of the facility. An interview on 08/18/10 at 11:45 AM with housekeeping staff #1 revealed she observed Resident #16 with his/her hand in Resident #14's pants touching Resident #14's pubic area on 07/22/10 and Resident #14 was yelling for help.</p> <p>Interviews with facility staff, conducted on 08/18/10 through 08/20/10 with Housekeeper #1, Licensed Practical Nurse (LPN) #1 and Nurse Aide (NA) #1 revealed Resident #16 wandered in other residents' rooms. Resident #16 had a favorite room (Resident #14's) and required frequent redirection out of that room. The staff revealed Resident #16 stared at "everybody's bottoms" and "prayed on female residents". Resident #16 had been in other residents' rooms touching him/herself sexually. Resident #16 was on 15 minute checks but none of the staff could verify who was responsible to implement the 15 minute checks and there was no procedure for documenting if the checks had been completed.</p> <p>Interviews with the Administrator on 08/19/10 at 6:35 PM and on 08/31/10 at 4:30 PM, revealed she failed to talk with the Medical Director prior to 07/22/10 and was aware of Resident #16's history of behaviors on 06/15/10, when she requested information from a former facility. There was not a policy or procedure for management of residents with sexual behaviors and staff had not been trained related to management of such behaviors. Resident #16's behaviors had been discussed in the morning meetings and staff were told to present reality that his/her behaviors were</p>	F 490	<p>F490 (continued)</p> <p>monitoring is occurring the resident will remain on the 24 hour report, to further communicate the need to monitor. The charge nurse is responsible to assure that the monitoring is being completed and recorded during their shift. The individual monitoring sheets will be reviewed by the Unit Managers and / or the Director of Nursing at or just prior to each morning AQA meeting to validate completion. Education for this policy and process was started on 8/30/10 and has been continued with oncoming workers in all departments at the start of their shift before reporting for duty. The training was provided by the Director of Nursing, MDS Coordinator, Quality Management Nurse, and Nursing Supervisors. The Director of Nursing will be responsible to provide training to any employees that are not immediately available for training, prior to their return to duty, utilizing the previously described process. A post test was given to verify understanding of the abuse policy, reporting requirements and recognizing inappropriate sexual behavior at the conclusion of the training. The administrator successfully completed the post test with a score with 100% accuracy. Education of the Inappropriate Sexual Behavior Management Policy and the Behavior Monitoring Policy have been added to the orientation materials that are covered with the Abuse Policy at the time of hire.</p> <p>The Care Plan team including Director of Nursing, MDS Coordinator, Unit Manager, Social Service Director, Activity Director, Dietary Director, Rehab Director and Administrator, were provided training regarding updating the plan of care as conditions arise and monitoring the effectiveness of the approaches that are in place. The training was conducted by Quality</p>	

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F 490	Continued From page 38 unacceptable. A psychiatric evaluation was discussed sometime during Resident #16's first week after admission,, but then no behaviors were documented for about a month so the psychiatric evaluation was not obtained. The Administrator stated she did not realize until the investigation of the 07/22/10 incident involving Resident #14, that Resident #16 was admitted with orders to follow up with psychiatric services. The Administrator stated Resident #16 had been on 15 minute checks due to inappropriate behaviors but no system was in place to verify completion of the checks or who was completing them. Additionally, there was no facility policy or procedure for 15 minute checks. The facility was unable to provide documented evidence that they provided necessary supervision and implemented effective interventions to manage the sexually aggressive behaviors of Resident #16 and protected the other residents in the facility from abuse. An acceptable Allegation of Compliance (AoC) was received 09/02/10. The actions taken to verify the removal of Immediate Jeopardy included a policy developed regarding Inappropriate Sexual Behavior Management on 08/30/10. The Administrator and staff were trained regarding this policy beginning on 08/30/10 and continuing with on-coming employees before they began work. A review of the Abuse Policy revealed an emphasis was placed on recognizing sexual abuse and inappropriate behaviors and the need to report any suspected abuse of any kind. A policy was developed on 08/30/10 describing the process to be followed when providing behavior monitoring including 1:1 monitoring and every 15 minute	F 490	F490 (continued) Management Specialist Nurses on 8/31/10. The process was revised to include physicians orders being brought to the morning Abbreviated Quality Assurance Meeting. The orders will be reviewed along with condition changes noted on the 24 hour reports. Any change in condition or order that requires a care plan update will be assigned to a team member, usually the Unit Manager, to add the intervention that is decided upon. The person who updates the care plan will report back to the Director of Nursing that the plan was updated in the next day's Abbreviated Quality Assurance Meeting. If conditions or behaviors are identified that suggest that the current care plan is ineffective, the care plan will be brought to the AQA meeting for revision. On weekends the care plans will continue to be updated with needed revisions by the charge nurses. The orders and report records for the weekend will be reviewed in the next weekday AQA meeting to verify that appropriate updates were made. Care plan revisions are not limited to this process and can be made at anytime that it is noted that a revision is indicated. When new interventions are added for a resident who exhibits sexually inappropriate behaviors, the resident and the intervention change will be added to the 24 hour report to monitor the effectiveness of the interventions. The resident will remain on the 24 hour report for at least seven days. If interventions are noted to be ineffective, the care plan will be revised as described above. On 8/31/10 re-education was conducted with the Social Service Director by the Quality Management Nurse. The re-education included review of the Social Service Director's job description, Abuse and Neglect Policy including the types of abuse, identifying abuse and reporting requirements. An emphasis	

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

PRINTED: 09/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2010	
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 39 monitoring. A post test was given to the Administrator and staff to verify understanding. The Immediate Jeopardy was verified removed on 09/02/10, as alleged in the AoC, with the scope/severity lowered to a "D", based on the facility's need to continue to evaluate the implementation of systematic changes.	F 490	F490 (continued) was placed on sexual abuse and sexually inappropriate behaviors, as well as, participation in the development of care plans and interventions to address sexually inappropriate behaviors and to promote the safety and wellbeing of other residents. The Social Service Director was able to list the types of abuse, provide examples of each abuse type, including sexual, physical, mental, verbal, corporal punishment, exploitation, or involuntary seclusion and describe the abuse reporting process. In the same training session, the Social Service Director was re-educated regarding utilizing the admission history and assessment process to aid in identifying potential risks for inappropriate sexual behaviors. If potential risks are identified the Social Service Director was trained to notify the Administrator and /or Director of Nursing or the On-Call designee, if both are not available. If immediate intervention is required she was trained to notify the charge nurse of the potential risk and assist in the development of the care plan and interventions to manage the potential risk. Additional training was provided to the Social Service Director on 9/1/10 by the Quality Management Specialist. The training included recording in objective terms, noting specific observations that are described clearly using words to paint a visual picture, observing for mood and behavior indicators to aide in assessing for changes in condition. Instruction was given to utilize quotations by the residents to help describe feelings objectively. The training also instructed to document situations and conditions that occur between routine quarterly documentation that may have impact	

F490 (continued)

on the residents psychosocial functioning. This would include such events as newly identified or worsening of behavioral symptoms, need for outside services, a change in medical condition that impacts overall condition, changes in family or close relationships, responses to stressful situations or unusual/traumatic events. She was trained that documentation was to be done as soon as possible following the event within the same workday so that details of observations are clear. Training also included the need for gathering complete and accurate social history and assessment to utilize the information to identify risk for behaviors or conditions that require social service or interdisciplinary intervention. It was also explained that information gathered is to be utilized in developing the MDS, RAPS and Care Plan. In the future, in the event inappropriate sexual behaviors are exhibited by a resident, the staff member's have been trained that their first responsibility is to protect other residents who are present or may come in contact with the resident.

All reports of sexually inappropriate behavior and/or sexual abuse will be immediately reported to the charge nurse. If the behavior is directed toward another resident, and the act of abuse is suspected; then the charge nurse will report the incident to the Administrator. The resident who exhibited the behavior will be placed on 1:1 monitoring while his behavior is being assessed by the charge nurse with guidance from the Director of Nursing or the Administrative Nurse on call. The behaviors exhibited will be evaluated for potential causative factors such as abnormal labs, infection, medication changes, impaired sleep

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F490 (continued)

habits, inappropriate hormone levels, impaired liver function, etc. The attending physician will be notified and involved in the assessment process as indicated. Based on findings, interventions such as those described in the Inappropriate Sexual Behavior Management Policy and training, will be put in place to protect the safety of other residents. Social Services will be involved in the assessment of the resident and his behaviors and a psychological service consult will be requested. The care plan will be updated to reflect the interventions that are implemented.

At the request of the facility, per the Administrative and Support Services Agreement, "Adventists" has provided educational and training and support to the Administrator, by the Quality Management Nurse, regarding recognizing abuse, the facility's Abuse Policy and the newly developed Inappropriate Sexual Behavior management Policy. This was completed on 08/30/2010. The Administrator was successfully tested on her understanding of the policies on 08/31/2010.

The Administrator was also educated and trained on the implementation of the policy and procedures developed regarding conducting one-to-one monitoring and when the procedure should be implemented to protect residents from potential harm. The education and training included monitoring the process that was instituted to ascertain that the monitoring is being carried out as planned. In addition, she was trained on the proper documentation of the process. The education and training on this policy and related processes was conducted by the Quality Management Nurse on 08/30/2010 and 08/31/2010.

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R490 (continued)

The Administrator was also provided education and training on the process previously described, by utilizing the 24 hour reports to identify behaviors that may require care plan intervention. The education and training included verification that the care plan interventions were added and implemented and the validation to determine if interventions are effective. This training was conducted with the Administrator by the Quality Management Nurse on 08/31/2010.

The Administrator was also re-educated on 09/01/2010 regarding the provision of medically related social services and the need for monitoring the services provided. The Administrator reviewed records, with the support of the Quality Management Nurse, to validate services and verify her understanding of the process. These reviews were conducted from 09/01/2010 through 09/30/2010. They will continue as behavioral symptoms are exhibited and at scheduled audit times. (See Monitoring Plan).

How will the corrective actions be monitored to ensure the deficient practice will not recur:-

The orders and 24 hour report records and the care plans for residents identified with behaviors will be reviewed in the next days Abbreviated Quality Assurance meeting to verify that the plan was updated and reflects interventions necessary to protect the safety and well being of other residents. If sexually inappropriate behaviors occur on the weekend, the care plan will be reviewed in the next weekday AQA meeting to verify that appropriate updates were made.

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F490 (continued)

Care plan revisions are not limited to this process and can be made at anytime that it is noted that a revision is indicated. When new interventions are added for a resident who exhibits sexually inappropriate behaviors, the resident and the intervention change will be added to the 24 hour report, to monitor the effectiveness of the interventions. The resident will remain on the 24 hour report for at least seven days. If interventions are noted to be ineffective, the care plan will be revised as described above.

A follow up post test to validate on-going understanding of education including, Abuse & Neglect, reporting of abuse, recognition of sexually inappropriate behaviors, reporting sexually inappropriate behaviors, and managing sexually inappropriate behaviors. The testing will be conducted every two weeks for eight weeks. If results indicate that someone doesn't understand, re-education will be provided on an individual basis. After eight weeks, if results of testing indicate understanding, re-testing will be conducted monthly for six months then quarterly. Monthly re-education will be conducted for three months then will be conducted quarterly by the Social Service Director, Director of Nursing, Quality Management Nurse or a guest speaker.

To verify that the Administrator will continue to monitor policies, procedures and processes in a manner that enables the facility to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, mental, and psychosocial well-being for each resident, the facility has requested that "Adventists" provide audit support.

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F490 (continued)

Appropriate representatives "Adventists," including the Quality Management Nurse and other licensed nurses and administrators, will conduct audits of administrative services. Services to be audited would include response to resident behavior, social services provided to residents, Monitoring of effectiveness of care plans and response to abuse allegations and actions/interventions implemented to prevent potential abuse of other residents. The audits will be conducted monthly on each of these areas for 3 months. If concerns are identified, further education and training support will be provided. If no concerns are identified, frequency of the audits will be changed to quarterly for 6 months and then annually if no further concerns are identified. If concerns are identified they will be reported to the facility's Quality Assurance Committee for recommendations for changes in audit content and/or increase in frequency.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2010
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NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 08/18/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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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.