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PRINTED: 08/11/2011  
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:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <small>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</small>	(X3) DATE SURVEY COMPLETED  C 08/09/2011
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NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
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F 000  F 280 SS=E	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey was initiated on 08/08/11 and concluded on 08/09/11 to investigate KY16851. The allegation was substantiated without regulatory violation. A deficiency unrelated to the allegation was cited. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, clinical records and facility policy, it was determined the facility failed to periodically review and revise the comprehensive care plan as changes in the residents needs where identified for three (3) of three (3) sampled</p>	F 000  F 280	<p>F-280: Facility Plan of Correction</p> <p>The facility will be in compliance with F-280 as of September 6, 2011.</p> <ol style="list-style-type: none"> <li>The facility took specific measures to correct the violation on August 9, 2011. For residents #1, #2, #3 their care plans were updated on August 11, 2011 by the social service director and MDS coordinators regarding resident behaviors, approaches, goals and interventions.</li> <li>Starting on August 11, 2011 members from the care plan team addressed each residents care plan to ensure that each resident had a care plan that reflected their behaviors or potential for behaviors. In order to enable the facility staff to care for the residents if there was a behavior was exhibited.</li> </ol>	

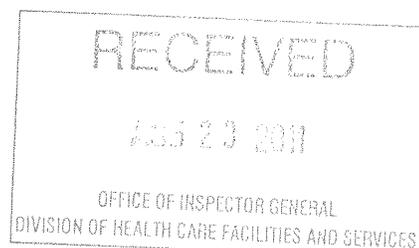
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Chesha Stasi* TITLE: *Administrator* (X8) DATE: *8/22/11*

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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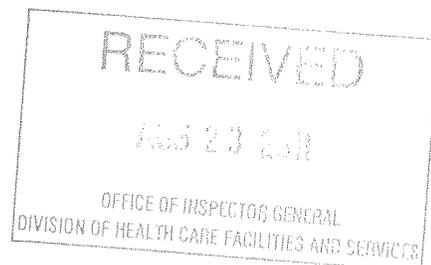
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F 280	<p>Continued From page 1</p> <p>residents (Resident #1, #2 and #3). Resident #1 was touched inappropriately by Resident #2 and Social Services planned for Resident #1 to be protected from Resident #2. In addition, Resident #2 was to be monitored when close to other residents. Resident #1 and Resident #2's care plans were not revised to reflect this plan. Resident #3 exhibited aggression towards other residents and the comprehensive care plan was not revised to reflect these events and interventions implemented to address aggressive behaviors.</p> <p>The findings include:</p> <p>Record review of the facility's policy for Comprehensive Assessment and Care Plan Documentation Guidelines, undated, revealed the facility would identify problems and develop a coordinated plan to provide care for each problem.</p> <p>1. Review of the clinical record for Resident #1, revealed the facility admitted the resident with a diagnosis of Alzheimer's Disease on 04/01/11. The facility completed an admission Minimum Data Set (MDS) assessment, on 04/11/11, which revealed the resident had disorganized thinking, was unfocused and wandered aimlessly in the facility on a daily basis. Resident #1's care plan, dated 07/06/11, revealed no evidence of interventions to protect Resident #1 from Resident #2. The social service notes, dated 07/29/11, revealed Resident #1 had been inappropriately touched by Resident #2 on 07/29/11. The Social Services Director</p>	F 280	<p>3. All of the interdisciplinary care plan team was inserviced on August 10, 2011 by the administrator on the importance of updating, and developing care plans in conjunction with the completion of a comprehensive assessment. The interdisciplinary team was also inserviced on August 10, 2011 of the importance of getting the input for the care plan from the resident and/or their responsible party. The team was also inserviced on the importance of adding information to the care plan as the needs, abilities, and behaviors of the residents change. The in-service instructed the interdisciplinary team to work as a team, and all members were informed and encouraged to add information to the resident care plan. In order to avoid this deficient practice in the future on August 18<sup>th</sup> 19<sup>th</sup> and 20<sup>th</sup> the nursing department CNAs and nurses were inserviced by the director of nursing, educational director</p>



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F 280	<p>Continued From page 2</p> <p>documented Resident #1 was to be protected from Resident #2.</p> <p>2. Review of the clinical record for Resident #2, revealed the facility admitted the resident with diagnoses of Cerebral Vascular Accident with Left Side Paralysis and Depression on 01/20/09 and readmitted the resident on 11/26/10. Resident #2 threatened to throw cold water on a roommate, and on 12/07/10, started hitting a resident in the hallway. There was no evidence provided to demonstrate the care plan was reviewed and/or revised after either incident. The facility completed a quarterly MDS assessment on 05/31/11 which revealed the resident was fully alert and oriented to person, time and place. The social service notes, dated 07/29/11, revealed Resident #2 exhibited inappropriate sexual behavior towards Resident #1 on 07/24/11 at 1:00 PM. Resident #2 was to be kept away from Resident #1 and Resident #2's behavior was to be monitored when around other residents.</p> <p>Review of the care plan for Resident #2, revealed no evidence of interventions to monitor the resident's behavior or to keep the resident away from Resident #1.</p> <p>3. Review of the clinical record for Resident #3, revealed the facility admitted the resident with diagnoses of Dementia with Behavior Disturbances, Psychosis and Depression on 08/18/06 and readmitted the resident on 11/17/10. The resident was admitted for psychiatric hospital stays in November 2010 and</p>	F 280	<p>and assistant director of nursing on the importance of documenting resident behaviors, where to document them and who to notify regarding behaviors. In order to capture behaviors nursing staff will log behavior issues regarding residents into the behavior binder, notify social services, report the behavior on the 24 hour report, and document in the nurse note of the medical record. The social service director and social service assistance were inserviced on August 15<sup>th</sup> by the administrator on the importance of reviewing the behavior binder daily when they are in the facility, and communicating with staff regarding resident behaviors and interventions. The social service director or social service assistant will check the behavior binder daily when they are in the building to capture any resident that may have had a change in condition. The</p>	



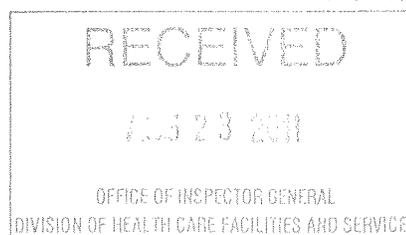
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F 280	<p>Continued From page 3</p> <p>January 2011 related to behaviors including hitting, shaking and pushing and threatening other residents.</p> <p>The facility completed a quarterly MDS assessment on 04/10/11 which revealed the resident had trouble concentrating, wandered, had increased anxiety and poor judgement.</p> <p>Review of the care plan for Resident #3, started on 11/04/11, revealed staff were to monitor, document and report the resident's behaviors and responses to interventions.</p> <p>Interview with the Social Services Director, on 08/09/11 at 3:10 PM, revealed she was told Resident #2 had touched Resident #1 inappropriately and she went to talk with the resident. She stated she planned for Resident #2's behavior to be monitored and to keep the resident away from Resident #1. She did not revise the care plans for Resident #1 or Resident #2, however, she told nursing to monitor the residents.</p> <p>Interview with MDS Coordinator #1, on 08/09/11 at 4:00 PM, revealed she did not revise the care plan for Resident #1, Resident #2 or Resident #3. She did not address these problems as each discipline was responsible for certain areas and social services care planned all behaviors, therefore, nursing did not participate in the revision of Resident #1, #2 or #3's care plans. She stated there was no reason the care plans were not addressed and the residents' behaviors could happen again.</p>	F 280	<p>social service director or social service assistant will interview the resident regarding the documented issue in the behavior binder. Social services with the assistance of the resident or the responsible party if the resident is not cognitively able will develop a plan of care related to the behavior. The care plan will contain the issue, interventions, goals and a target goal date. Social services will also document in the resident record the decision, intervention and goals established by the resident or responsible party. If no conversation occurred regarding this issue the reason why it did not occur will be documented in the resident medical record. Documentation regarding follow up will occur to ensure the resident is reaching stated goals. Any behaviors that occur with residents will be discussed 5 days a week in manager's morning meeting. If a behavior occurs that requires the administrator, DON, and Social</p>	



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F 280	Continued From page 4  Interview with the Director of Nursing, on 08/09/11 at 4:00 PM, revealed the care plan team needed to communicate more effectively and care plan resident problems as a team.	F 280	Service Director to be notified related to suspected abuse the Administrator, DON, and Social Service Director will be notified immediately.  4. On a weekly bases for 3months starting August 15, 2011 the administrator or quality assurance director will audit the behavior binder. When behaviors are noted in the binder the administrator will review the social service notes, nurse's notes and care plan to assure the issues have been addressed. After the 3 month period of weekly monitoring the monitoring will go to monthly. Weekly starting on August 15, 2011 for the next 3 months the director of nursing or quality assurance director will review 3 residents that had a care plan developed in accordance with the comprehensive assessment schedule to ensure that the care plan reveals an interdisciplinary team approach and that the resident and or responsible party was included.	

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After the 3 month period of weekly monitoring the monitoring will go to monthly the director of nursing or designee will audit 10 care plans that were developed as a result of a comprehensive assessment to ensure that the care plan reveals an interdisciplinary team approach and that the resident and or responsible party was included.

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