

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

PRINTED: 10/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/15/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
(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 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/15/15 as alleged.</p>	{F 000}		
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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185137	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 10/15/2015
Name of Facility WESTMINSTER TERRACE	Street Address, City, State, Zip Code 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0160</u> Reg. # <u>483.10(c)(6)</u> LSC _____	Correction Completed 10/15/2015	ID Prefix <u>F0253</u> Reg. # <u>483.15(h)(2)</u> LSC _____	Correction Completed 10/15/2015	ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed 10/15/2015
ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed 10/15/2015	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 10/15/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 10/15/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>mg</u>	Reviewed By <u>kt</u>	Date: <u>10/19/15</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>10/19/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/11/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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F 000	INITIAL COMMENTS	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to convey funds upon death to close the account within thirty (30) days for two (2) of five (5) unsampled deceased residents. Unsampled Resident A and Unsampled Resident B. The findings include: Review of the Resident Trust Fund Statement for Unsampled Resident A revealed the resident expired 04/25/15; however, the account was not closed until 06/30/15, thirty-four (34) days late. Review of the Resident Trust Fund Statement for Unsampled Resident B revealed, the resident expired 04/21/15; however, the account was not closed until 06/04/15, thirteen (13) days late. Interview with the Administrator, on 09/11/15 at	F 160	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F160: <i>Corrective action for residents affected:</i> Resident A & B no longer reside in the facility. The Trust Fund for Resident A was closed on 6/30/2015. The Trust Fund for Resident B was closed on 6/4/2015. <i>How facility will identify other residents with potential to be affected:</i> A review of the discharges over the last 12 months was conducted by the Administrator on 9/30/2015.	10/15/15

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

TITLE

(X6) DATE

[Signature]

Administrator

10/2/15

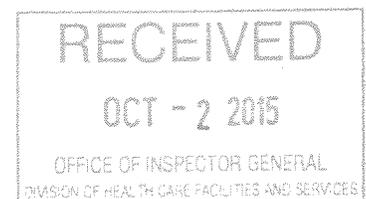
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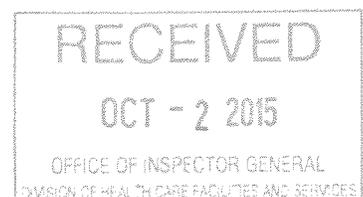
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F 160	Continued From page 1 11:20 AM, revealed the delay in closing the accounts occurred due to poor communication between the facility and corporate office in a timely manner.	F 160	This review found that no other residents were affected.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure resident's closet doors were kept in good repair for fifteen (15) of fifty-eight (58) rooms, Rooms #132, #133, #135, #136, #139, #140, #142, #234, #237, #239, #240, #249, #250, #251, and #254. The findings include: Review of the facility's policy regarding Maintenance Work Orders, not dated, revealed in order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director. Observations, on 09/09/15 at 9:26 AM, revealed room 251-1 the closet door was completely off the hinges. At 2:25 PM, in room 237-1 the closet door was not attached. The resident stated the door had fallen three times. At 3:22 PM, rooms 132-2, 133-1, and 135-1, the right door hinge was missing. At 3:35 PM, room 136-2 and 139-2 the	F 253	<i>What systemic changes will be put in place to insure deficiency does not reoccur:</i> On 10/01/2015 The Administrative Assistant, The Accounts Payable Clerk and the Personal Care Administrator were inserviced by the Administrator on the requirements for closing Resident Trust Accounts with in 30 days. The Administrative Assistant will log all discharge residents and will log date of the residents trust account being closed. Weekly the Administrative Assistant will report the results of the discharged residents log to the Administrator. <i>How facility plans to monitor its performance to make sure solutions are sustained:</i>		



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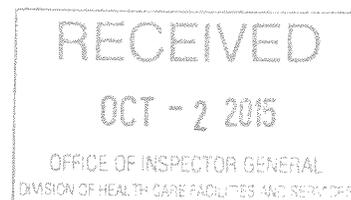
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F 253	<p>Continued From page 2</p> <p>right hinges were missing. At 3:42 PM room 140 had two right hinges missing. Continued observations on 09/10/15 revealed the closet door hinges either right, left or both sides missing in rooms 142, 239-1, 240-2, 249-1, 250-2, and 254-2. In room 234-1, the closet door was missing.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 09/09/15 at 2:25 PM, revealed she was aware the door hinge in room 237-1 was off. The upper right closet door hinge and middle hinge were missing. She stated, she had not completed a work order.</p> <p>Interview with the Director of Maintenance, on 09/09/15 at 2:45 PM, revealed he was unaware of the closet door hinges needing repair. He stated nursing was to fill out a work order for needed repairs.</p> <p>Further interview with the Maintenance Director, on 04/11/15 at 5:25 PM, revealed he had been working on the closet doors for the last thirteen (13) years. If a resident hits the closet door with a wheelchair the door will come off. There had been talks of renovation in the past, but nothing definite. The Maintenance Director stated he did not have any work orders as it related to the Resident closet doors. He made rounds to each room weekly and was shocked so many resident doors were in need of repair. He stated he had come up with a plan to remove the hinge and place a continuous hinge, but needed the approval of the Administrator to do so. He stated it was a pretty extensive cost to replace all of the hinges at one time.</p> <p>Interview with the Acting Administrator, on</p>	F 253	<p>Weekly for 3 months the Administrator will review the discharged resident log with the Administrative Assistant to ensure timely closing of residents trust accounts.</p> <p>Monthly for 3 months the Administrator will report the results of the audits to Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee can make further recommendations s needed.</p> <p>The Administrator is responsible for obtaining and maintaining compliance</p> <p>F 253: <i>Corrective action for residents affected:</i></p> <p>Residents in rooms #132, #133, #135, #136, #139, #140, #142, #234, #237, #239, #240, #249, #250, #251, #254 have had their closet doors repaired.</p>	10/15/15	



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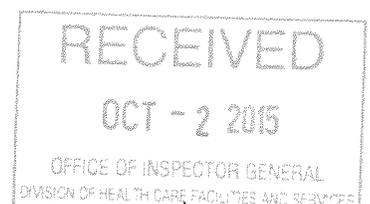
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F 253	Continued From page 3 09/11/15 at 6:00 PM, revealed he was not aware the closet doors were in need of repair and had not heard of any renovation plans. The Administrator stated the doors needed to be fixed and their was no reason as to why they were not fixed. The Acting Administrator stated the door could be an accident problem and fixing the doors should be a priority.	F 253	<i>How facility will identify other residents with potential to be affected:</i> An audit of all Closet Doors was completed by the Maintenance Director on 9/22/2015. This audit indicated that 15 closet doors needed to be repaired. All repairs have been completed by the Maintenance Director.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the	F 280	<i>What systemic changes will be put in place to insure deficiency does not reoccur:</i> Weekly the Maintenance Director will audit all closet doors in the building and will complete any needed repairs. Staff was educate and October 9th by the Staff Development Director on completion of Maintenance work orders. Weekly the Maintenance Director will review any open work orders, repairs completed and the audit of closet doors with the Administrator.		



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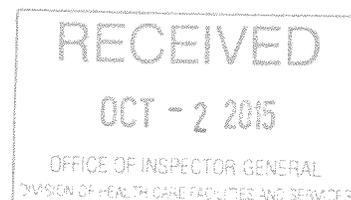
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F 280	<p>Continued From page 4</p> <p>facility failed to have an effective system in place to ensure care plans were revised for one (1) of eighteen (18) sampled residents, Resident #14. The staff failed to revise the care plans to include physician ordered fall mats, bunny boots, low bed and a brace to the left foot of Resident #14.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Comprehensive Care Plans, reviewed December 2011, revealed assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition changed. The Care Planning/Interdisciplinary Team were responsible for the review and revision of the care plans.</p> <p>Review of Resident #14's record revealed the facility admitted the resident on 04/06/15 with diagnoses of Muscle Weakness, Difficulty in Walking, Symbolic Dysfunction, Lack of Coordination, Dementia without behaviors and Generalized Pain.</p> <p>Review of Resident #14's Physician Orders, dated 09/02/15, revealed Resident #14 was ordered to weight bear as tolerated (WBAT) to left ankle while the brace was on, a low bed with fall mats at all times and bunny boots to both heels.</p> <p>Review of Resident #14's Comprehensive Care Plan, labeled: For long term care services needed to provide activities for daily living, dated 04/06/15, revealed Resident #14 was to weight bear as tolerated and to have a brace to his/her ankle at all times except when sitting.</p> <p>Review of Resident #14's Comprehensive Care</p>	F 280	<p><i>How facility plans to monitor its performance to make sure solutions are sustained:</i></p> <p>Weekly for 3 months the Administrator will review the maintenance log, work Orders, completed repairs and audits of closet doors.</p> <p>Monthly for 3 months the Maintenance Director will report the results of the audits to Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee can make further recommendations s needed.</p> <p>The Maintenance Director is responsible for obtaining and maintaining compliance.</p> <p>F 280: <i>Corrective action for residents affected:</i></p> <p>Resident #14 care plans were reviewed and revised by the MDS coordinator to ensure that the care plans included Physician ordered</p>	10/15/15	



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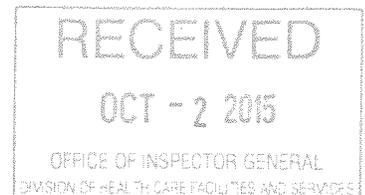
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F 280	<p>Continued From page 5</p> <p>Plan, labeled: History of falls, dated 04/06/15, revealed there were no documented interventions about fall mats or a low bed.</p> <p>Review of Resident #14's Comprehensive Care Plan, labeled: Pressure, dated 04/06/15, revealed there was no documented interventions for bunny boots to both heels.</p> <p>Review of Resident #14's Certified Nursing Assistant (CNA) Card, not dated, located on Resident #14's closet door, revealed no bunny boots, or brace to left foot when weight bearing nor a low bed.</p> <p>Observation of Resident #14, on 09/10/15 at 4:21 PM, revealed the resident was sitting in his/her wheelchair at the nurses station. The resident had an alarm attached to the back of his/her blouse and wheelchair. There were no bunny boots or a brace applied to the foot of the resident.</p> <p>Observation of Resident #14, on 09/11/15 at 9:26 AM, revealed the resident was sleeping in his/her bed. There was a fall mat on the right side of bed in the up position and not lying flat on the floor. There was no fall mat to the left of the bed. Resident #14's bunny boots were laying on top of his/her blanket and his/her feet were under the blankets. There was no ankle brace present to Resident #14's feet and the bed was found positioned in the medium high position.</p> <p>Interview with Certified Nursing Assistant (CNA)#1, on 09/11/15 at 9:46 AM, revealed he did not normally work with Resident #14. CNA #1 stated he was not familiar with Resident #14's care in regards to the brace to left ankle, bunny</p>	F 280	<p>Interventions of fall mats, bunny boots, low bed, use of brace and weight bearing status.</p> <p>Resident #14 CNA care card was removed from the closet door by the DON. The CNA daily care guide was revised by the MDS coordinator to include Physician ordered interventions of fall mats, bunny boots, low bed, use of brace and weight bearing status.</p> <p>Resident #14 was placed on hourly checks by the clinical coordinator to ensure Physician ordered interventions of fall mats, bunny boots, low bed, use of brace and weight bearing status are in place.</p> <p><i>How facility will identify other residents with potential to be affected:</i></p> <p>An audit of all current residents Physician Orders, Care Guides and Careplans were reviewed by the Director of Nursing 85 residents had corrections to their careplans and care guides.</p>		



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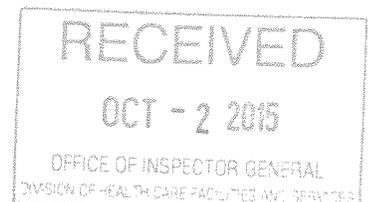
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F 280	<p>Continued From page 6</p> <p>boots, fall mats and the low bed. CNA #1 stated he did not know he was to utilize an ankle brace to Resident #14's ankle when pivoting during a transfer. CNA #1 stated Resident #14 needed minimal assistance. CNA #1 stated if he needed to know how to care for a resident he would go to the CNA Care Card located on the closet. He stated he would like to know this information.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/11/15 at 9:58 AM, revealed she was not familiar with Resident #14, but did see the treatment plan that stated Resident #14 was to have a brace to support his/her ankle. LPN #1 stated she did not revise the CNA care cards or the nursing care plans. It was the responsibility of the Clinical Coordinator.</p> <p>Interview with LPN #6, on 09/11/15 at 10:17 AM, revealed the nursing staff could revise the CNA care cards in the computer system. LPN #6 stated it was mandatory that the nursing staff print out the CNA care cards. LPN #6 stated if she made a change to the CNA care card she would reprint the care card and place on the resident's closet.</p> <p>Interview with the Registered Nurse (RN) Clinical Coordinator, on 09/11/15 at 4:00 PM, revealed the nursing care plans were revised by the Minimum Data Set (MDS) Coordinator. The RN Clinical Coordinator stated she updated the CNA care cards. She stated the CNA care cards should have been updated to reflect the fall mats, bunny boots and the low bed. The brace, fall mats and low bed were ordered to prevent falls and support Resident #14's ankle. The RN Clinical Coordinator stated she was not aware of any falls with Resident #14 concerning the non</p>	F 280	<p><i>What systemic changes will be put in place to insure deficiency does not reoccur:</i></p> <p>All current residents Physician Orders were reviewed by the Director of Nursing. CNA care cards were removed from the closets by the Clinical Coordinator. Physician ordered interventions were placed on the residents care plans and on the daily care guide by the MDS Coordinator. C.N.A & Licensed Nurses were notified by the Director of Nursing that the daily care guides will be used and CNA care cards were removed from closet doors. C.N.A staff was notified to review the residents care guides for changes. Licensed Nurses were notified that if any changes need to be made to the care guide that the MDS Coordinator is responsible for updating the daily care guides and the residents careplans.</p> <p>The Policy and Procedure for revising care plans and the daily care guide was reviewed and revised by the Administrator and the Director of Nursing on Oct 1st, 2015.</p>	



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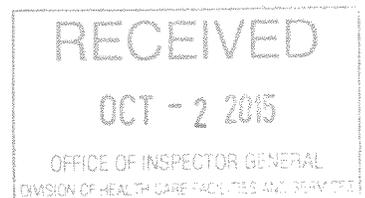
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
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F 280	Continued From page 7 use of his/her brace. She stated the bunny boots were utilized to prevent skin breakdown to the heels. She stated she was not sure who was responsible to monitor the CNA care cards that were in the residents' rooms. The CNA care cards were to be revised and printed out the same day. She stated the nurses were able to revise the care cards and print them out. Interview with the MDS Coordinator, on 09/11/15 at 4:39 PM, revealed the care plans were initiated upon admission and revised quarterly. The MDS Coordinator stated during the morning meetings, they decide as a group who would be responsible to initiate a specific care item. She stated if there was a new item she would at times revise the CNA care cards. The staff were expected to follow the care plans. The MDS Coordinator stated there was a problem with revising care cards and care plans. In the little time she had been the MDS Coordinator, she noted what was in the computer system did not match the care plans and could cause the resident's to not receive the proper care needed. Interview with the Director of Nursing (DON), on 09/11/15 at 5:04 PM, revealed the CNA care cards and care plans should be revised quarterly and as needed and the nurses were responsible to print out the care cards. The DON stated she was not a fan of the CNA care card in the resident's closet because it seemed to be inconvenient to revised the care card and family members may see things that should have been revised.	F 280	Licensed Nurses and Certified Nursing Assistants were in-serviced on daily care guides, Physician ordered safety interventions and procedure for revising daily care guides and the residents plan of care by the Staff Development Coordinator on Oct 2 nd and Oct 9 th . <i>How facility plans to monitor its performance to make sure solutions are sustained:</i> Weekly for 3 months the Director of Nursing, Clinical Coordinator and MDS Coordinator will review 20 residents clinical records to ensure Physician ordered interventions are on the residents care plan and on the residents daily care guide. Weekly for 3 months the Director of Nursing and the Clinical Coordinator will conduct visual audits or 20 residents to ensure Physician ordered interventions are in use per Physician orders. Weekly for 3 months the Director of Nursing will report the results of the audits to the Administrator.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			



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

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F 282	<p>Continued From page 8</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 follow the resident's Comprehensive Care Plan to prevent falls by ensuring adequate monitoring and supervision for one (1) of eighteen (18) sampled residents, Resident #6. Resident #6 had a history of multiple falls from the wheelchair, observations on 09/10/15 and 09/11/15 revealed the resident sleeping in the wheelchair and leaning forward with no staff present. Staff failed to monitor the resident as careplanned to encourage the resident to go to bed when sleeping in the wheelchair.</p> <p>The findings include:</p> <p>Review of the Comprehensive Care Plan Policy, revised on December 2011, revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs would be developed for each resident. Each residents comprehensive care plan would be designed to identify problem areas, incorporate risk factor's associated with identified problems and aid in preventing or reducing declines in the resident's functional status and or functional level.</p> <p>Review of the facility's policy regarding Falls -</p>	F 282	<p>Monthly for 3 months the Director of Nursing will report the results of the audits to Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee can make further recommendations s needed.</p> <p>The Director of Nursing is responsible for obtaining and maintaining compliance</p> <p>F282</p> <p><i>Corrective action for residents affected:</i></p> <p>Resident # 6 Fall Careplan was reviewed and revised by the MDS coordinator to reflect current safety needs.</p> <p><i>How facility will identify other residents with potential to be affected:</i></p> <p>An audit of all current residents Physician Orders, Care Guides and Careplans were reviewed by the Director of Nursing 85 residents had corrections to their careplans and care guides.</p> <p><i>What systemic changes will be put in place to insure deficiency does not reoccur:</i></p>	10/15/15



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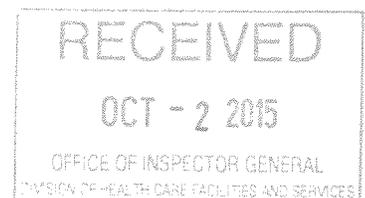
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F 282	<p>Continued From page 9</p> <p>Clinical Protocol, revised December 2011, revealed following a resident's fall the staff would evaluate and document findings of the event to determine the root cause of the fall. The staff would then develop relevant interventions to reduce or eliminate falls. The staff would monitor the developed interventions to determine the resident's response and the need for further evaluation and revision of the interventions.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident on 08/13/13 with diagnoses of Debility, Muscle Weakness-General, Lack of Coordination, Syncope and Collapse, Cardiovascular Accident (CVA) and Dementia with Behavior Disturbances.</p> <p>Review of the Falls Comprehensive Care Plan for Resident #6, dated 02/02/15, revealed a plan was developed with updated goals and target date of 12/01/15. The problem stated the resident was at risk for falls related to cognitive deficits, functional decline, and psychotropic medication usage. The goal stated the resident would be free of falls through the review period. The Falls Care Plan interventions directed the staff to continue to provide frequent (no designated time frame to define "frequent") safety checks, re-direction and monitoring the resident while in the wheelchair in the dining room; however, the interventions were not dated to show that the interventions were initiated, reviewed or revised.</p> <p>Review of the Certified Nursing Assistant (CNA) care card, no date provided, revealed Resident #6 was care planned to be encouraged to lay down if sleeping when up in wheelchair. Resident #6 was care planned to be checked every two (2) hours for incontinence, but not care planned to be</p>	F 282	<p>All current residents Physician Orders were reviewed by the Director of Nursing. All current residents' safety interventions were reviewed by the Director of Nursing.</p> <p>CNA care cards were removed from the closets by the Clinical Coordinator</p> <p>Physician ordered interventions were placed on the residents care plans and on the daily care guide by the MDS Coordinator.</p> <p>The Policy and Procedure for revising care plans and the daily care guide was reviewed and revised by the Administrator and the Director of Nursing on Oct 1st, 2015.</p> <p>The Policy and Procedure for Fall & Incident Management was reviewed and revised by the Administrator and Director of Nursing on Oct 1st, 2015.</p> <p>Licensed Nurses and Certified Nursing Assistants were in-serviced on daily care guides, Physician ordered safety interventions and procedure for revising daily, fall prevention and monitoring of residents, care guides and the residents plan of care by the Staff Development Coordinator on Oct 2nd and Oct 9th.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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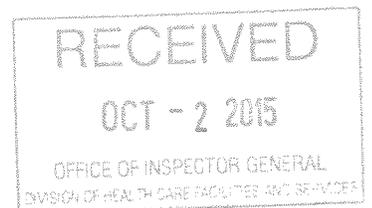
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F 282	<p>Continued From page 10</p> <p>monitored frequently, nor monitoring the resident when up in wheelchair as stated in the Falls care plan.</p> <p>Review of the Resident Incident Report for Resident #6, dated 04/24/15 at 6:32 AM, revealed a non-witnessed fall where the resident attempted to stand up unassisted from the wheelchair.</p> <p>Review of the Resident Incident Report for Resident #6, dated 04/28/15 at 6:16 PM, revealed a non-witnessed fall where the resident was sitting in the wheelchair reaching for something and then found sitting on the floor, legs were extended and the resident's back was against the wheelchair behind him/her.</p> <p>Review of the Resident Incident Report for Resident #6, dated 05/01/15 at 6:00 PM, revealed a non-witnessed fall where the resident was noted reaching for something and slipped out of the wheelchair and was found on the floor in the dining room which resulted in two skin tears to the right upper back side of the arm.</p> <p>Review of the Resident Incident Report for Resident #6, dated 09/05/15 at 2:45 PM, revealed a non-witnessed fall where the resident stood up to get out of the wheelchair and fell forward hitting his/her face on the floor and sustained a Hematoma to the right side of the forehead.</p> <p>Observation of Resident #6, on 09/10/15 at 8:15 AM, on the second (2) floor dining room revealed the resident was in the wheel chair at the table and no staff was present. Extensive bruising was noted on the resident's right side of the face and forehead, right front and mid side of the neck and shoulder with healing in various stages.</p>	F 282	<p><i>How facility plans to monitor its performance to make sure solutions are sustained:</i></p> <p>Weekly for 3 months the Director of Nursing, Clinical Coordinator and MDS Coordinator will review 20 residents clinical records to ensure Physician ordered interventions are on the residents care plan and on the residents daily care guide.</p> <p>Weekly for 3 months the Director of Nursing and the Clinical Coordinator will conduct visual audits on 20 residents to ensure Physician ordered interventions are in use per Physician orders.</p> <p>Weekly for 3 months the Director of Nursing and Clinical Coordinator will audit 20 residents' clinical records to ensure the Plan of Care is being following.</p> <p>Weekly for 3 months the Director of Nursing will report the results of the audits to the Administrator.</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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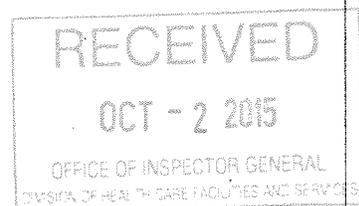
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F 282	Continued From page 11 Observation of Resident #6, on 09/10/15 at 9:10 AM, 9:35 AM, 9:55 AM, revealed the resident was in the hallway sleeping in the wheelchair, the upper body was leaning forward with no staff present. Observation of Resident #6, on 09/11/15 at 9:45 AM, revealed Resident #6 was sitting in the wheelchair in the hallway sleeping with their head leaning forward with no staff present. Observation of Resident #6, on 09/11/15 at 10:35 AM, revealed the resident was in the hallway in the wheelchair sleeping leaning their head forward and resting on his/her hand without staff present. Interview, on 09/11/15 at 10:00 AM, with Certified Nursing Assistant (CNA) #4, revealed Resident #6 freely wheeled around the second floor unit in his/her wheelchair and liked to go into the Dining/Day Room. She also stated Resident #6 was pleasantly confused and would have to be re-directed throughout the day. CNA #4 stated frequent monitoring to her meant checking on the resident less than every two (2) hours, such as every thirty (30) minutes or up to an hour (1). The CNA stated she was aware of Resident #6's history of falls and the care plan interventions to monitor frequently and to encourage him/her to go to bed when sleeping while up in his/her wheelchair. At this time the CNA stated she was not going to encourage the resident to go to bed because she knew the resident well and the resident would wake up and attempt to ambulate without assistance, which could result in another fall.	F 282	Monthly for 3 months the Director of Nursing will report the results of the audits to Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee can make further recommendations s needed. The Director of Nursing is responsible for obtaining and maintaining compliance	



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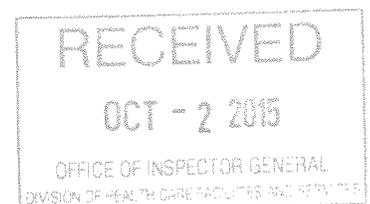
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F 282	<p>Continued From page 12</p> <p>Interview, on 09/11/15 at 1:45 PM, with Certified Nursing Assistant (CNA) #3, revealed safety checks for her meant checking every two (2) hours for fall mats or mattresses on the floor, alarms and seeing the resident. For fall risk residents it depended on the resident, it was individualized to each resident. The checks were documented in the Care Tracker for CNA's. Frequent monitoring to her meant less often than every two (2) hours, but wasn't sure how often.</p> <p>Interview, on 09/11/15 at 2:00 PM, with Licensed Practical Nurse (LPN) #2, revealed frequent monitoring meant every fifteen (15) to thirty (30) minutes and would be documented in the computer or sometimes on paper. Most of the time the residents were just visualized while the nurses were passing medications and this was not documented. LPN #2 stated if a resident had multiple falls he/she should be monitored more than every two (2) hours for safety checks. When safety checks were performed, she would assess for working alarms, proper placement of alarms and visualized the resident in general.</p> <p>Record review of Resident #6's medical record, revealed only two (2) hour toileting checks were completed, but no safety checks were documented.</p> <p>Interview, on 09/11/15 at 2:35 PM, with the Minimum Data Set (MDS) Coordinator, revealed she and the Director of Nursing (DON) revised and added to the post fall care plan the interventions and each intervention should be dated with the date initiated. Frequent safety checks written on a care plan meant for all staff members in general to view the resident for safety more often during their shift. The MDS</p>	F 282			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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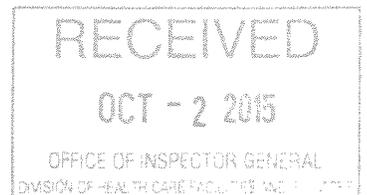
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F 282	Continued From page 13 Coordinator stated the frequent safety checks intervention should specify how often and should be documented by the staff. Further interview with the MDS Coordinator, on 09/11/15 at 4:39 PM, revealed when she wrote the intervention for monitoring the resident more frequently, she meant for the resident to be monitored hourly. The MDS Coordinator stated her documentation was in need of help. She stated if Resident #6 was monitored hourly it could have prevented his/her fall in which he/she sustained a hematoma. Interview with the DON, on 09/11/15 at 5:04 PM, revealed staff were expected to follow the care plans. The DON stated she was accustomed to the care plan being more specific; however, Resident #6's care plan was not specific to how often to monitor the resident. The DON further stated if a staff member was not a routine care giver for Resident #6 she would expect them to go to the resident's closet to see how to provide care for the resident. She stated the CNA care card and care plans should match the orders the physician had written and the staff were expected to follow the care plans and physician orders.	F 282	F309 <i>Corrective action for residents affected:</i> Resident # 14 Physician Orders were reviewed by the Director of Nursing. <i>How facility will identify other residents with potential to be affected:</i> An audit of all current residents Physician Orders, 85 residents had corrections to their current Physician orders. <i>What systemic changes will be put in place to insure deficiency does not reoccur:</i> All current residents Physician Orders were reviewed by the Director of Nursing. Residents Physicians were contacted for order clarifications as indicated by the DON and Clinical Coordinator. Physician ordered interventions were placed on the residents care plans, MAR/TAR and on the daily care guide by the MDS Coordinator.	10/15/15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309			



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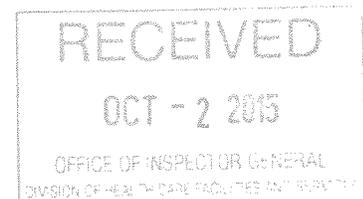
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F 309	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to follow physician orders for one (1) of eighteen (18) residents, Resident #14. The staff failed to apply bunny boots, a brace and place fall mats and a low bed as ordered by the physician. The findings include: No policy could be provided for following the physician orders. Review of Resident #14's clinical record revealed the facility admitted the resident on 04/06/15, with diagnoses of Muscle Weakness, Difficulty in Walking, Symbolic Dysfunction, Lack of Coordination, Dementia without behaviors, Generalized Pain. Review of Resident #14's Physician Orders, dated 09/02/15, revealed Resident #14 was ordered a low bed with fall mats at all times and bunny boots to both heels. In addition, the resident was to weight bear as tolerated (WBAT) on the left ankle with a brace on. Observation, on 09/10/15 at 4:21 PM, revealed Resident #14 was sitting in his/her wheelchair at the nurses station. The resident had an alarm attached to the wheelchair and their top. The resident did not have bunny boots or brace applied to the feet. Observation, on 09/11/15 at 9:26 AM, revealed Resident #14 was sleeping in his/her bed. There	F 309	A Policy and Procedure for following of Physician orders was implemented by the Administrator and the Director of Nursing on Oct 1st, 2015. Licensed Nurses were in-serviced by the Staff Development Director on Oct 2 nd & 9 th on the policy for following Physician orders. <i>How facility plans to monitor its performance to make sure solutions are sustained:</i> Weekly for 3 months the Director of Nursing, Clinical Coordinator and MDS Coordinator will review 20 residents' clinical records to ensure Physician orders are being followed. Weekly for 3 months the Director of Nursing will report the results of the audits to the Administrator. Monthly for 3 months the Director of Nursing will report the results of the audits to Quality Assurance Performance Improvement (QAPI)		



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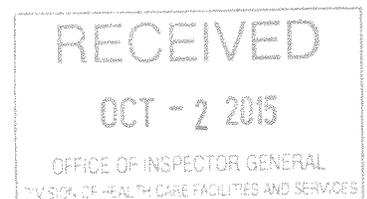
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F 309	<p>Continued From page 15</p> <p>was a Fall mat on the right side of bed; however, it was not laying on the floor next to the bed and there was no fall mat on the floor next to the left side of the bed. Resident #14's bunny boots were laying on top of the blanket and the resident's feet were under the blanket. Resident #14 did not have a brace on the left foot and the bed was found in the medium high position.</p> <p>Interview with CNA #1, on 09/11/15 at 9:46 AM, revealed he did not normally work with Resident #14. CNA #1 stated someone had placed Resident #14 in the bed on 09/11/15. He was not familiar with the brace, boots, low bed or fall mats that Resident #14 was to utilize. CNA #1 stated he did not know Resident #14 needed a brace to pivot when transferring.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 and observation of Resident #14's room, on 09/11/15 at 9:58 AM, revealed she was not familiar with Resident #14 having a brace, but once she reviewed the treatment log she realized the Resident was to utilize a brace. Observation of Resident #14's room, revealed the brace was stored in the resident's closet, on the top shelf in the back.</p> <p>Interview with the Registered Nurse (RN) Clinical Coordinator, on 09/11/15 at 4:00 PM, revealed she remembered Resident #14 having some form of a brace on. The RN Clinical Coordinator stated when she observed Resident #14, he/she was usually in his/her wheelchair and was not sure how staff transferred the resident. The RN Clinical Coordinator stated the brace, fall mats and low bed were utilized to prevent falls and the bunny boots were utilized to prevent skin breakdown to the back of Resident #14's heel.</p>	F 309	<p>Committee. The QAPI Committee can make further recommendations s needed.</p> <p>The Director of Nursing is responsible for obtaining and maintaining compliance.</p>	



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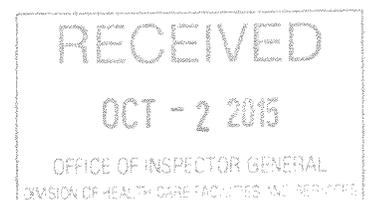
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F 309	Continued From page 16 The RN Clinical Coordinator stated she expected staff to follow the physician's orders.	F 309	F323 <i>Corrective action for residents affected:</i>	10/15/15
F 323 SS=D	Interview with the Director of Nursing (DON), on 09/11/15 at 5:04 PM, revealed she expected the staff to follow physician orders. The DON stated the nurses on the unit were responsible to ensure the CNA staff followed the physician orders. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure adequate supervision to prevent accidents was provided for one (1) of eighteen (18) sampled residents, Resident #6. The staff failed to complete frequent checks as care planned and the resident sustained a fall on 09/05/15 resulting in a Hematoma to the right side of the forehead. In addition, the facility failed to ensure the environment was free of water temperatures in excess of and above one hundred and ten (110) degrees Fahrenheit (F) for one (1) of two (2) units, the 200 Unit. Water temperatures tested on 09/10/15 ranged from 112 to 114 degrees (F).	F 323	Resident # 6 careplan, Physician Orders, Daily care guide and careplans were reviewed by the Director of Nursing, Clinical Coordinator and MDS Coordinator. Temperatures on the 200 Unit were adjusted and monitored by the Maintenance Director until the optimal temperature of less than 110 degrees was achieved. Staff were notified and instructed to not use the water on the 200 Unit by the Director Of Nursing. The Administrator was notified by the Director Of Nursing. <i>How facility will identify other residents with potential to be affected:</i> An audit of all current residents Fall Careplans were reviewed by the Director of Nursing 85 residents had corrections to their careplans.	



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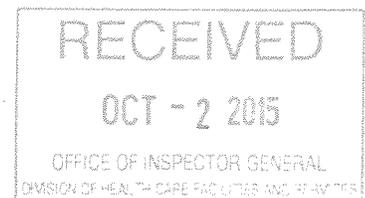
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F 323	Continued From page 17 The findings include: Review of the facility's policy regarding Falls - Clinical Protocol, revised December 2011, revealed the interdisciplinary team would evaluate the resident's history of falls and risk factors for subsequent falling. In addition, the nurses would assess precipitating factors, details on how the falls occurred and staff would document findings in the resident's chart. Following a resident's fall the staff would evaluate and document findings of the event to determine the root cause of the fall. The staff would then develop relevant interventions to reduce or eliminate falls. Staff would monitor the developed interventions to determine the resident's response and the need for further evaluation and revision of the interventions. Review of the facility's policy regarding Assessing Falls and Their Cause, revised October 2010, revealed the purpose of the policy was to provide guidelines to assess a resident after a fall to assist staff in identifying causes of the fall. In identifying causes of the fall or fall risk the staff would evaluate chains of events or circumstances preceding a recent fall, including time of day, time of last meal, what the resident was doing, witnessed or un-witnessed, environmental risks involved, and whether there was a pattern of falls for the resident. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/13/13 with diagnoses of Debility, Muscle Weakness-General, Lack of Coordination, Syncope and Collapse, Cardiovascular Accident (CVA) and Dementia with Behavior Disturbances.	F 323	6 residents were at risk for less than optimal water temperatures. The staff were notified and instructed not to use the water by the Director of Nursing. <i>What systemic changes will be put in place to insure deficiency does not reoccur:</i> All residents that have incidents will have their Physician Orders, daily care guides and careplans will be reviewed by the IDT. Incidents will be investigated to identify a root cause and have an intervention implemented. The Policy and Procedure for revising care plans and the daily care guide was reviewed and revised by the Administrator and the Director of Nursing on Oct 1st, 2015. The Policy and Procedure for Fall & Incident Management was reviewed and revised by the Administrator and Director of Nursing on Oct 1st, 2015. Licensed Nurses and Certified Nursing Assistants were in-serviced on daily care guides, Physician ordered safety interventions and procedure for revising daily, fall prevention		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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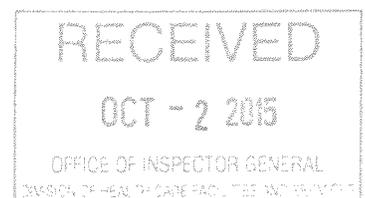
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F 323	Continued From page 18 Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #6, completed on 08/24/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of three (3) out of a total score of fifteen (15) which meant the resident was not interviewable. Review of the Falls Comprehensive Care Plan for Resident #6 dated 02/02/15, revealed a plan was developed with updated goals and target date of 12/01/15. The problem stated the resident was at risk for falls related to cognitive deficits, functional decline, and psychotropic medication usage. The goal stated the resident would be free of falls through the review period. The Falls Care Plan interventions directed the staff to continue to provide frequent (no designated time frame to define "frequent") safety checks, re-direction and monitor the resident while in the wheelchair in the dining room; however, the interventions were not dated to show the interventions were initiated, reviewed or revised. Observation of Resident #6, on 09/10/15 at 8:15 AM, in the second (2) floor dining room revealed the resident was at the table sitting in a wheel chair with no staff present in the room. Extensive bruising was noted on resident's right side of the face and forehead, right front and mid side of the neck and shoulder with healing in various stages. Review of the Resident Incident Report for falls, for Resident #6, dated 02/06/15 at 9:39 PM, revealed a staff member witnessed the resident stand from the wheel chair without assistance after removing shoes and fell onto the floor, alarm intact. The initial intervention was to continue to	F 323	and monitoring of residents, care guides and the residents plan of guides and the residents plan of care by the Staff Development Coordinator on Oct 2nd and Oct 9th. The Safety of Water Temperatures policy was reviewed by the Maintenance Director and The Administrator on Oct 1st, 2015. Weekly the Maintenance Director will randomly sample water temperatures for 20 resident rooms and common areas for temperatures greater then 110 degrees Fahrenheit. Any temperatures found to be greater then 110 degrees Fahrenheit will be corrected immediately. Staff were inserviced on water temperature requirements, the policy of Safe Water Temperatures and how to contact the Maintenance Director should unsafe temperatures be suspected. <i>How facility plans to monitor its performance to make sure solutions are sustained:</i>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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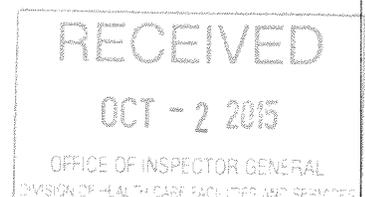
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F 323	<p>Continued From page 19</p> <p>monitor the resident (with no designated time frame or what was being monitored). The follow up intervention dated 02/18/15, was for staff to monitor the resident closely when up in wheel chair.</p> <p>Review of Resident #6's medical record, revealed no documented evidence that Resident #6 was being closely monitored or monitored while in wheelchair.</p> <p>Review of the Resident Incident Report for falls, for Resident #6, dated 04/24/15 and timed 6:32 AM, revealed the resident attempted to stand unassisted from the wheel chair and sustained a non-witnessed fall. The initial intervention was to take the resident to the dining room. Further review of the Resident Incident Report for the follow up intervention, dated 04/30/15, was for staff to continue to monitor and provide re-direction as needed.</p> <p>Review of Resident #6's medical record, revealed no documented evidence for monitoring and re-direction of the resident.</p> <p>Review of the Resident Incident Report for Resident #6, dated 04/28/15 and timed 6:16 PM, revealed the resident was sitting in the wheel chair reaching out and sustained a non-witnessed fall by sitting on the floor, legs were extended and their back was to the wheel chair behind him/her. The initial intervention was to assess and assist the resident back to the wheel chair. The follow up intervention, dated 04/30/15, was for staff to continue monitoring Resident #6 for changes and provide frequent re-direction and safety cues related to poor safety awareness (no designated time frame to define "frequent").</p>	F 323	<p>Weekly for 3 months the Director of Nursing and Clinical Coordinator will review residents with any type of incident to ensure that the IDT has reviewed the interventions. The director of nursing will ensure that incidents were investigated and that interventions have been implemented.</p> <p>Weekly for 3 months the Director of Nursing will report the results of the audits to the Administrator.</p> <p>Weekly for 3 months the Maintenance Director will conduct audits to ensure that water temperatures are optimal.</p> <p>Weekly for 3 months the Maintenance Director will review the results of the audit with the Administrator.</p> <p>Monthly for 3 months the Director of Nursing will report the results of the audits to Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee can make further recommendations as needed.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 20</p> <p>Review of Resident #6's medical record, revealed no documented evidence for monitoring and re-direction of the resident.</p> <p>Review of the Resident Incident Report for Resident #6, dated 05/01/15 and timed 6:00 PM, revealed the resident was noted reaching for something and slipped out of the wheel chair and sustained a non-witnessed fall to the floor in the dining room which resulted in two skin tears on the right upper back side of the arm. The initial intervention was first aid. The follow up intervention, dated 05/06/15, revealed staff was to monitor for changes and continue current interventions.</p> <p>Review of Resident #6's medical record, revealed no evidence of documented monitoring for safety.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 09/11/15 at 10:00 AM, revealed Resident #6 went to the dining room frequently. Resident #6 liked the television and activities. Resident #6 freely propelled him/her self in the dining room and hall ways on the unit. CNA #4 stated the resident was pleasantly confused and was not aware of his/her surroundings and thinks he/she was with the spouse from the past. Resident #6 was placed in the halls so that he/she was frequently monitored.</p> <p>Observation of Resident #6, on 09/10/15 at 9:10 AM, 9:35 AM, 9:55 AM, revealed the resident was in the hallway sleeping in the wheelchair leaning the upper body forward with no staff present. Continued observation of Resident #6, on 09/11/15 at 9:45 AM, revealed Resident #6 was in the wheelchair in the hallway sleeping with their</p>	F 323	<p>The Director of Nursing is responsible for obtaining and maintaining compliance</p> <p>Monthly for 3 months the Maintenance Director will report the results of the audits to Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee can make further recommendations s needed.</p> <p>The Maintenance Director is responsible for obtaining and maintaining compliance.</p>		



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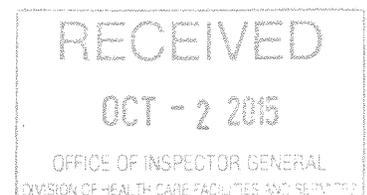
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F 323	<p>Continued From page 21</p> <p>head leaning forward with no staff present. Observation of Resident #6, on 09/11/15 at 10:35 AM, revealed the resident was in the hallway in the wheelchair sleeping leaning head forward resting on his/her hand without staff present.</p> <p>Interview with the Licensed Practical Nurse (LPN) #3, on 09/09/15 at 2:00 PM, revealed on 09/05/15 at 2:45 PM Resident #6 was laying down and staff had gotten Resident #6 up because he/she was restless. Resident #6 was placed in his/her wheelchair and was taken to the dining room. The resident was in his/her wheelchair by his/her self and was not monitored. LPN #3 stated she did not have a time frame as to how long Resident #6 was by him/her self in the dining room.</p> <p>Review of the Resident Incident Report for Resident #6, dated 09/05/15 at 2:45 PM, revealed a non-witnessed fall where the resident stood up to get out of the wheel chair and fell forward hitting his/her face on the floor and sustained a Hematoma to the right side of the forehead. The initial intervention was to keep the resident in arms reach at all times.</p> <p>Further review of Resident #6's medical record revealed no documentation to support the staff kept the resident in arms reach at all times.</p> <p>Interview with LPN #3, on 09/09/15 at 2:00 PM, revealed she checked the residents on her team in the beginning of the shift for working alarms and safety checks while she did her vital signs. Each shift did safety checks along with the Certified Nursing Assistants (CNA) and to her knowledge there was no where to document completed safety checks.</p>	F 323			

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

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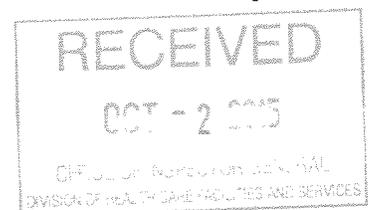
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F 323	<p>Continued From page 22</p> <p>Interview, on 09/11/05 at 10:30 AM, with LPN #1, revealed safety checks to her meant checking that the alarms are in working order and visualize the resident's presence at least every two hours, or more frequently for residents who were a risk for falls or behaviors. However, there are no designated areas for nurses to document safety checks when completed.</p> <p>Interview, on 09/11/15 at 2:00 PM, with LPN #2, revealed frequent monitoring meant every fifteen (15) to thirty (30) minutes and document in the computer or sometimes on paper. Most of the time the residents were just visualized while the nurses were passing medications and this was not documented. LPN #2 stated if a resident had multiple falls he/she should be monitored more than every two (2) hours for safety. When safety checks were performed, she looked for working alarms, proper placement of alarms and visualized the resident in general.</p> <p>Interview with the Registered Nurse (RN) Clinical Coordinator, on 09/11/15 at 1:30 PM, revealed during the AM (morning) stand ups the interdisciplinary team met to review the falls and discussed all the clinical concerns. The RN Clinical Coordinator stated there was no concerns identified with the fall on 09/09/15 because the fall was an isolated fall and there was no fall since 05/01/15. She felt because of all of the things that were put into place there were no concerns.</p> <p>Interview, on 09/11/15 at 2:35 PM, with the Minimum Data Set (MDS) Coordinator, revealed frequent safety checks written on a care plan meant for all staff members in general to view the resident for safety risks more often during their shift. The MDS Coordinator stated frequent safety</p>	F 323			



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

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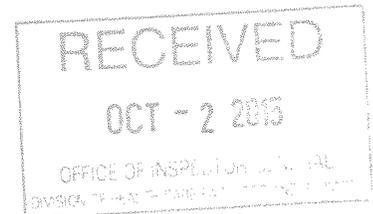
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F 323	<p>Continued From page 23</p> <p>check interventions should specify how often and should be documented by the staff. She also stated if this would have been better communicated to the staff, Resident #6 may not have sustained a fall with injury, referring to the 09/05/15 fall.</p> <p>Further interview with the MDS Coordinator, on 09/11/15 at 4:39 PM, revealed when she wrote the intervention for monitoring the resident more frequently, she meant for the resident to be monitored hourly. The MDS Coordinator stated her documentation was in need of help. She stated if Resident #6 was monitored hourly it could have prevented his/her fall in which he/she sustained a hematoma.</p> <p>Interview, on 09/11/15 at 3:00 PM, with the Director of Nursing (DON), revealed since July 2015 (she was hired at this time) the facility had gone through a transition period and were aware there were areas that needed revision and staff needed to be re-educated.</p> <p>2. Review of the facility's policy regarding The Safety of Water Temperatures, revised December 2011, revealed water temperatures in the facility would be kept within a temperature range to prevent scalding of residents. Water temperatures would be no more than 110 degrees (F).</p> <p>Review of the water temperature log book, revealed monitoring of the water temperatures were done bi-weekly and the water temperatures ranged between 107 degrees (F) to 110 degrees (F).</p> <p>Observations of water temperatures, on 09/10/15</p>	F 323			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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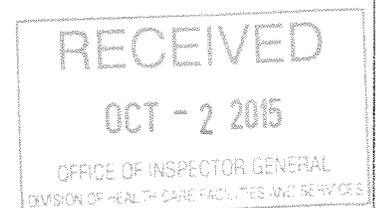
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F 323	<p>Continued From page 24</p> <p>at 4:15 PM, revealed the facility's water temperatures in the following rooms exceeded 110 degrees: Room 243 was 114 degrees (F); room 239 was 114 degrees (F); and, room 237 was 112 degrees (F). In the shower room on the second floor across from the Director of Nursing's office, the hand washing sink had a water temperature of 112 degrees (F).</p> <p>Observation with the Maintenance Director, on 09/10/15 at 4:43 PM, revealed the Maintenance Director rechecked the water with his device and confirmed the water temperatures were in excess of 110 degrees (F) in rooms, 243, 239, 237, and the second floor shower room. The Maintenance Director adjusted the temperature down and waited for the water to circulate in the building.</p> <p>Review of the temperature log for 09/10/15 revealed temperatures taken at 5:25 PM in room 246 was 109.1, at 6:07 PM in room 243 was 109.4, at 6:15 PM in room 239 was 106.5 and at 11:02 PM the shower room was 105.9.</p> <p>Interview with the Maintenance Director, on 09/11/15 at 5:25 PM, revealed the problem with the water temperatures was a bad valve. He stated there were two (2) systems sitting side by side. The one (1) system was at 140 degrees (F) which was utilized by the Janitors and slop sinks for sanitizing and it was back flowing into the 110 degree (F) system which was utilized by the residents. The Maintenance Director stated the water temperatures for residents should be between 100 to 110 degrees (F)t. If the water temperatures were above 110 degrees (F) it could cause residents to become scalded by the water. The Maintenance Director stated he monitored the water once (1) every two (2) weeks</p>	F 323		



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

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F 323	<p>Continued From page 25 and chose random rooms with a shower room, with no concerns.</p> <p>Review of the work order from a local vendor, dated 09/11/15, revealed he found the hot supply to be back feeding the check valves in the boiler room. He shut the circulating pump on 140 degrees (F) temperature, turned the line off and closed the valve to prevent crossover into the tempered water system. Rooms were maintaining correct readings at that time.</p> <p>Interview with the Acting Administrator, on 09/11/15 at 6:00 PM, revealed he became aware of the water temperatures being elevated by the Director of Nursing. The protocol for elevated water above 110 degrees (F) was to notify the Administrator and make sure family members, visitors and residents were safe. The Acting Administrator stated he had not been reviewing the water log temperatures, though he was the Maintenance Directors supervisor.</p>	F 323			



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

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218	
(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
{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/02/15 as alleged.	{K 000}		

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.