

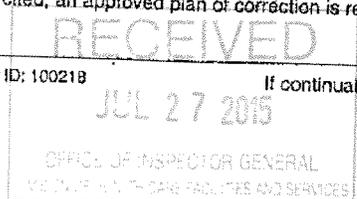
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

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|--|---|--|--|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185039 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>06/18/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HIGHLANDS HEALTH AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1705 STEVENS AVENUE<br>LOUISVILLE, KY 40205   |                      |  |
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| F 000  | <p>INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 06/02/15 and an Extended Survey was initiated on 06/15/15 and concluded on 06/18/15. Immediate Jeopardy was identified on 06/04/15 and determined to exist on 01/06/15 at 42 CFR 483.35 Dietary Services (F371) at a scope and severity of a J, at 42 CFR 483.70 Physical Environment (F469) at scope and severity of a K; and at 42 CFR 483.75 Administration (F490) and (F520) at a scope and severity of a K. Substandard Quality of Care was identified at 42 CFR 483.15 Housekeeping and Maintenance (F253) at a scope and severity of an F. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 06/04/15.</p> <p>Review of the Pest Technician Service Report, dated 01/06/15, revealed the Pest Technician placed four (4) RTU (container to deliver bait to kill mice) baits down and five (5) glueboard traps down in the kitchen area for mice. Observations, and interviews revealed the kitchen dry storage room continued with mice droppings (as identified by the Pest Technician) and in the medication rooms, clean linen rooms, soiled utility rooms and nurses stations. Record review revealed mice or other pests had been identified in the kitchen and the laundry with staff and resident sightings of mice since 12/24/14 and as recent as 06/01/15. Resident interviews revealed mice had chewed on bags of chips delivered on their meal tray and chewed on a box of doughnuts in their room. Observations revealed a bug crawling on a resident's wheelchair during an interview and gnats swarming around a resident's urinal.</p> <p>Additional deficiencies were cited at 42 CFR</p> | F 000  | <p>Highlands POC:</p> <p>To the best of my knowledge and belief, as an agent of Highlands Health and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> |                      |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X *Roger Tullham* TITLE: X *Administrator* (X6) DATE: X *7/26/15*

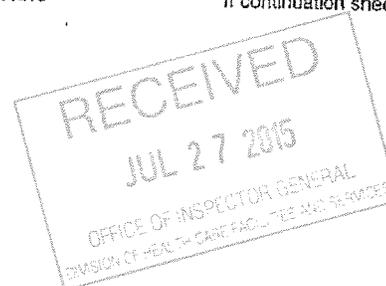
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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| F 000  | Continued From page 1<br>483.20 Resident Assessment (F280) and (F282) at a Scope and Severity of a "D"; 42 CFR 483.25 Quality of Care (F309) and (F323) at a Scope and Severity of a "D"; at 42 CFR 483.35 Dietary Services (F364) at a Scope and Severity of an "E"; and, 42 CFR 483.75 Administration (F514) at a Scope and Severity of a "D".<br><br>The facility provided an acceptable Allegation of Compliance on 06/11/15 alleging removal of Immediate Jeopardy on 06/10/15. The State Survey Agency validated the removal of Immediate Jeopardy prior to exit on 06/18/15, as alleged. The Scope and Severity was lowered to a "D" at 42 CFR 483.35 Dietary Services (F371); 42 CFR 483.70 Physical Environment (F469) was lowered to a Scope and Severity of an "E"; and, 42 CFR 483.75 Administration (F490 and F520) was lowered to a Scope and Severity of an "E" while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. | F 000  |  |                      |  |
| F 253<br>SS=F  | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the facility's in-service and policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, uncluttered building in good repair for twelve of thirty-two  | F 253  | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>The fall mat located in the room of resident #19 (136) that was found to be dirty was removed from the room on 6/2/15.<br>The floor in the room of resident #19 was cleaned on 6/2/15.<br>The bathroom floor, toilet and area behind the toilet and bathroom walls in the room of Residents C & D (237) were cleaned by housekeeping staff on 6/5/15. The resident curtains in room 237 were cleaned on 6/5/15 by laundry staff. The room and bathroom in room 237 is cleaned daily and as needed by housekeeping staff. |                      |  |



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| F 253  | <p>Continued From page 2</p> <p>sampled residents (Residents #1, #5, #6, #9, #13, #15, #16, #18, #19, #27, #28 and #29); and, six (6) of nine (9) unsample residents (Unsampled Resident C, D, F, G, H and I) and twenty-one (21) of eighty-eight (88) resident rooms.</p> <p>Observations of the above twenty-one (21) resident rooms revealed walls were in disrepair, cove-base moldings pulled from the walls, a wooden handrail splintered, an ice machine that leaked a large pool of water standing on the floor, door thresholds with built up wax imbedded with brown/black substance, doors and door thresholds with black scuff marks and peeling paint, toilets soiled with urine/feces, and black scuff marks and sticky substances on the floors in four (4) of four (4) resident living units, Unit 1B, Unit 1C, Unit 2B and Unit 2C. Further observation on 06/17/15 There was approximately fourteen (14) feet of a metal handrail that was loose from the wall and wobbly.</p> <p>The findings include:</p> <p>Review of the facility's in-service (presented as the housekeeping policy), dated 01/01/00, revealed resident room walls should be spot scrubbed, both sides of the doors scrubbed, build-up on floors between rooms and hallways should be removed, and bathrooms should have all fixtures, drains and pipes cleaned with a germicide and all stains and build-up removed daily. The facility did not present a policy regarding cleaning of the halls, storage rooms, nursing stations or common resident living areas.</p> <p>1. Observation of room #136 on Unit 1B</p> | F 253  | <p>The doorframe of Resident #9 (239) was painted by Maintenance staff on 6/8/15.</p> <p>The floor of room 241 where residents #15 and #29 reside was cleaned by housekeeping staff on 6/5/15.</p> <p>The resident room floor and bathroom floor in room 243 where resident #18 resides was cleaned by housekeeping staff on 6/5/15. In addition, the door frame for room 243 was painted by Maintenance staff on 6/8/15.</p> <p>The items noted in the room of Resident #5 that were stored directly on the floor were relocated by nursing staff on 6/4/15.</p> <p>The room of Resident #5 is cleaned daily and as needed by housekeeping staff.</p> <p>Room 106 where resident #13 resides was cleaned by housekeeping staff on 6/5/15.</p> <p>The commode elevated seat and toilet in the room of resident #16 (145) was cleaned by housekeeping staff on 6/5/15 and is cleaned daily and as needed.</p> <p>Trash is emptied daily and as needed for Resident #16 residing in Room 145.</p> <p>The floor and window seal in Room 139 where Resident #1 and Resident I reside was cleaned by housekeeping staff on 6/5/15.</p> <p>The gouged section of dry wall identified to exist in room 148 where Resident #6 and Resident H reside was repaired by maintenance staff on 6/8/15. The floor in this room is cleaned daily and as needed by housekeeping staff.</p> <p>The furniture was dusted and the floor was cleaned inn Room 225 where Resident #28 resides by housekeeping staff on 6/5/15.</p> <p>The floor in room 226 where Resident F and Resident G reside was cleaned by housekeeping staff on 6/5/15.</p> <p>The toilet in room 203 where Resident 27 resides is cleaned daily and as needed by housekeeping staff.</p> |                      |  |

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| F 253  | <p>Continued From page 3</p> <p>(Sampled Resident #19), during the initial tour, on 06/02/15 at 8:20 AM, revealed a fall mat directly under bed 2 (Resident #19). This mat was covered with paper candy wrappers, used tissues, and dirt and dust-like particles. In addition, there was an approximate two (2) inch area of brown/black substance on the floor around the perimeter of the mat.</p> <p>2. Observation during the initial tour of Unit 2B, on 06/02/15 at 8:30 AM, revealed a microwave located in an unidentified room with dried, dark yellow/brown substances on the interior of the microwave.</p> <p>3. Observation, on 06/02/15 at 8:33 AM, of Unit 2B, revealed room #237 (Unsampled Residents C and D), had dark brown/yellow substances on the bathroom floor, a strong urine odor, a piece of a belt and toilet paper laying in the corner behind the toilet with yellow/brown stains and dark brown streaks on the wall next to the toilet. At 8:40 AM, room #239 (Resident #9), had chipped paint which allowed bare metal of the entry doorframe to be visible. Observation at 8:36 AM, of room #241 (Residents #15 and #29) revealed white paper debris and black dirt and food crumbs on the floor. At 8:43 AM, room #243 (Resident 18), had a soiled floor, an entry doorframe with chipped paint and a heavily soiled bathroom floor threshold. At 8:44 AM, room #244 had a strong urine odor and black dirt on the floor. At 8:45 AM, rooms #245 and #249 had soiled floors that were streaked and sticky. At 8:47 AM, the hallway wallpaper between rooms #247 and #249 had wallpaper that was torn in fifteen (15) places.</p> <p>Continued observation of Unit 2B, on 06/02/15 at 1:31 PM, revealed room #224 had a smear of a</p> | F 253  | <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br/>All residents have the potential to be affected.</p> <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?<br/>An audit of all resident rooms was conducted by the Maintenance Director and Maintenance Assistant on 7/13/15 to identify walls that were in disrepair and cove-base moldings pulled from the wall. Walls identified to be in disrepair and cove-base moldings pulled from the wall were repaired by 7/18/15.<br/>Handrails were inspected by the Maintenance Director on 6/16/15 for areas that may cause splintering. Any identified areas were sanded by 6/17/15.<br/>Ice machines were inspected by the Maintenance Director on 6/18/15 to identify leaks. No leaks were noted to exist.<br/>An audit was conducted of the entire nursing center by the Housekeeping Manager on 6/7/15 to identify door thresholds and floors that needed cleaning. Cleaning of identified door thresholds was completed by 7/18/15.<br/>An audit was conducted by the Maintenance Director on 6/5/15 to identify doors and door threshold that were scuffed or had peeling paint. Doors identified were painted or cleaned by 6/9/15.<br/>An audit was conducted by the Housekeeping Manager on 7/13/15 of all resident toilets to identify those that needed to be cleaned. The identified toilets were cleaned by 7/18/15.</p> |                      |  |

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| F 253  | <p>Continued From page 4</p> <p>dried, brown substance behind the resident's clean towel linens which were hanging on the towel rack in the bathroom. At 1:35 PM, room #228 (Resident #5) revealed multiple items stored directly on the floor to include clothing, craft beads, wire, glue, sugar and salt packets, pillows, plastic bags, an open fruit cup, paper bags, pictures, stuffed toys, newspaper, three (3) soiled washcloths, a bag of briefs and multiple other items.</p> <p>Interview with Resident #5 (room #228 Unit 2B), on 06/02/15 at 4:56 PM, revealed the resident had been allowed to keep housekeepers out of his/her room because the resident did not want it cleaned.</p> <p>Interview with Certified Nurse Aide (CNA) #6, on 06/03/15 at 2:30 PM, revealed Resident #5 (Room #228 Unit 2B) collected everything and the floor space in the resident's room was so full that housekeeping could not sweep or mop the floor. She stated the resident's room smelled bad from lack of cleaning; however, nursing staff was advised (she couldn't remember by whom) that the resident had the right to forbid cleaning of the room and changing of the bed linens.</p> <p>Interview with the Assistant Director of Nursing (ADON) #3, on 06/04/15 at 12:11 PM, revealed the staff had been trying to clean Resident #5's room, but had no cooperation from the resident. She stated she knew Resident #5's room was dirty, and that it was the facility's responsibility to have the room cleaned. The ADON stated she was unaware staff had been told that Resident #5 had the right to refuse housekeeping services. She further stated housekeeping services had been poor for the past several months due to the</p> | F 253  | <p>An audit was conducted by the Housekeeping Manager of all resident rooms on 7/13/15 to identify floors that were in need of cleaning. Identified floors were cleaned by 7/18/15.</p> <p>The metal handrail noted on Unit 1B on the Activities corridor to have been loose was repaired by the Maintenance Director on 6/19/15. All other handrails were inspected by the Maintenance Director on 6/19/15 to identify any that were loose. Those rails noted to be loose were repaired.</p> <p>The microwave that is located on Unit 2B that was noted to be dirty, as well as all other microwaves located on resident units was cleaned on 6/5/15 by housekeeping staff. An audit was conducted by the Maintenance Director on 7/13/15 to identify wall paper that was torn. Areas identified were repaired by 7/18/15.</p> <p>The blood pressure machine on the 2B unit was cleaned by nursing staff on 7/10/15.</p> <p>An inspection of the kick plates of all resident doors was conducted by the Maintenance Director on 6/6/15 to identify any in need of repair. Identified repairs were completed by 6/9/15.</p> <p>The snack room door window identified to be streaked with tape residue was cleaned by housekeeping staff on 6/5/15.</p> <p>An inspection was completed of all service doors in the center on 6/6/15 by the Maintenance Director to identify any that were dirty or in need of painting or repair. Identified issues were resolved by 6/9/15.</p> |                      |  |

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| F 253  | <p>Continued From page 5<br/>housekeeping staff shortage and loss of the housekeeping directors.</p> <p>4. Observations, on 06/02/15 at 1:43 PM, of room #237 Unit 2B (Unsampled Residents C and D), revealed the bathroom continued with dark brown and yellow substances on the floor, a strong urine odor, a piece of a belt and toilet paper laying in the corner behind the toilet with yellow/brown stains and dark brown streaks on the walls next to the toilet. In addition, observation of room #241 Unit 2B (Residents #15 and #29), on 06/02/15 at 1:45 PM, revealed the room continued to have white paper debris, black dirt and food crumbs on the floor which were sticky.</p> <p>Observation of room #237 Unit 2B (Unsampled Residents C and D), on 06/03/15 at 1:47 PM and on 06/04/15 at 8:21 PM, revealed the bathroom continued with dark brown and yellow substances on the floor, a strong urine odor, a piece of a belt and toilet paper laying in the corner behind the toilet with yellow/brown stains and dark brown streaks on the walls next to the toilet.</p> <p>Observation of room #237, on 06/04/15 at 8:21 AM, revealed no change from the initial tour. Yellow food items were still observed on the floor with dark brown substances on the floor in the room. The bathroom was observed to have yellow and brown substances on the floor. Toilet paper and the piece of a belt, lying in the corner, behind the toilet, was found to have brown and yellow substances. Strong odors of urine were coming from the bathroom. Dark brown streaks were observed coming up along the wall next to the toilet. The residents' curtains in the room were observed to have brown stains on them.</p> | F 253  | <p>4. How will the facility monitor performance to ensure solutions are sustained?<br/>To maintain continued compliance, the Administrator completes an Environmental Facility Tour sheet on weekly basis that reviews cleanliness in public areas, resident rooms and non-resident areas. The results of this audit are reviewed with the Environmental Manager. Physical Plant / Maintenance rounds are completed weekly in conjunction with the pest control rounds to identify maintenance issues within the center. The staff has been educated by the Staff Development Coordinator, DNS and ADNSs on completing Maintenance Work orders on 6/5/15 completed on 6/9/15. Work orders are reviewed by Maintenance Director and completed by priority.</p> <p>The results of the Environmental and Maintenance rounds will be reviewed during the center's monthly QAPI meeting, attended by: Administrator, Medical Director, DNS and two or more of the following: ADNS, MDS Nurse, Dietary, Social Services, Activities, Maintenance, Housekeeping or Specialized Rehab Therapy. Any additional interventions to maintain continued compliance will be discussed and implemented.</p> | 7-22-15              |  |

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| F 253  | Continued From page 6<br><br>Interview with Unsampled Resident C (Room #237 Bed 1 Unit 2B), on 06/04/15 at 8:30 AM, revealed the resident cleaned his/her own bathroom. Unsampled Resident C further stated housekeeping cleaned the room on an average of two (2) times a week and then would only sweep and mop. Unsampled Resident C stated housekeeping would not clean the bathroom.<br><br>5. Observation of Unit 1C, room #106 (Resident #13), on 06/02/15 at 8:35 AM, revealed the room had a strong odor of urine.<br><br>6. Observation of Unit 1B, room #145 (Resident #16), on 06/02/15 at 3:07 PM, revealed a white powdery substance on the commode elevated seat and a dried brown substance on the front and the inside of the toilet.<br><br>Review of Resident #16's clinical record revealed the facility assessed the resident with a score of fifteen (15) of fifteen (15) on the Brief Interview for Mental Status (BIMS), on 04/17/15, meaning the resident was interviewable.<br><br>Interview with Resident #16 (room #145), on 06/04/15 at 2:42 PM, revealed he/she stated housekeeping did not remove his/her bedroom trash daily.<br><br>7. Observation of Unit 2B, on 06/03/15 at 8:30 AM, revealed Housekeeper #4 getting his cleaning cart ready to clean the unit. Further observation of Unit 2B, on 06/03/15 at 10:20 AM, revealed Housekeeper #4 left the unit, after approximately one hour and fifty minutes. Additional observation, on 06/03/15 at 1:45 PM, | F 253  |   |                      |  |

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| F 253 | <p>Continued From page 7</p> <p>revealed Housekeeper #4 was not on the unit and was not observed by the Surveyor, the remainder of the day.</p> <p>Interview with the Environmental Services #1, on 06/04/15 at 9:53 AM, revealed Housekeeper #4, worked on 06/04/15 on the unit. Environmental Services #1, stated Housekeeper #4 was suppose to stay on the unit from the hours of seven 7:00 AM to 3:00 PM. There was a lunch break from 12:00 PM to 1:00 PM and Housekeeper #4 should have been back on the unit. Environmental Services #1 was shocked to observe room #237 and stated he saw bowel movement on the walls and floors and smelled urine. He stated there was no excuse for the lack of cleanliness. Environmental Services #1 stated there could be a problem with monitoring the staff to ensure the housekeeping was being completed. Environmental Services #1 stated he did not monitor the Housekeeping staff to ensure they completed their tasks.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 06/04/15 at 10:01 AM, revealed she did not think the unit was clean. She stated it smelled and could be cleaner. CNA #5 stated the floors were not clean, the bathrooms were horrible and she did not like to go into the bathrooms herself. She stated she felt the lack of cleanliness could make the residents feel embarrassed. She stated she had not seen housekeepers on the unit often and she thought the facility could not employ enough housekeepers. CNA #5 stated the facility was expecting the CNAs to clean the bathrooms.</p> <p>Interview with Licensed Practical Nurse (LPN) #8,</p> | F 253 |  |  |
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| F 253 | <p>Continued From page 8</p> <p>on 06/04/15 at 9:26 AM, revealed she felt the residents' rooms were not as clean as they should be and she had heard the residents complain about the uncleanliness of their rooms. LPN #8 stated she tried to pitch in and clean some of the residents' rooms. She stated she had observed bowel movement on the floor and often smelled urine odors coming from the bathroom in room #237. LPN #8 stated she did not expect the residents to have to clean their own bathrooms. She further stated the unclean environment could make the residents feel like no one cared about them.</p> <p>Interview with LPN #9, on 06/04/15 at 9:41 AM, revealed when she observed Unsampled Resident C's room, she saw "poop" on the bathroom wall. She stated there had been some problems with housekeeping, somedays she saw them only half a day and somedays not at all and she never saw housekeeping on the weekend. LPN #9 stated after lunch she did not see the Housekeeper on the unit for the remainder of day on 06/03/15. She further stated the lack of cleaning may make the residents feel awful. LPN #9 stated she tried to clean when residents complained, but it was difficult at times to clean and complete her nursing duties. She stated she knew she would not want to live like that. LPN #9 stated out of all the rooms on the 2 B unit, she thought none of the rooms were clean and they "...were all filthy".</p> <p>8. Observation of room #139 Unit 1B (Resident #1 and Unsampled Resident I), on 06/03/15 at 8:40 AM, revealed multiple particles of dust-like debris on the residents' window sill and dirt/debris throughout the bedroom floor.</p> | F 253 |  |  |
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| F 253              | <p>Continued From page 9</p> <p>9. Observation of room #148 Unit 1B (Resident #6 and Unsampld Resident H), on 06/03/15 at 8:48 AM, revealed a large (approximately six [6] by five [5] inches) gouged section of dry wall beside Resident #6's bed (bed 2) and multiple scrapes and gray/black brown discolorations of the drywall beside Unsampld Resident H's bed (bed 1) at eye level.</p> <p>Interview with Resident 6's family member, on 06/03/15 at 2:35 PM, revealed Resident #6's bedroom floor was dirty with debris (room #148 Unit 1B) often in the past several months when she came to visit.</p> <p>10. Observation of the 2B Unit nursing station, on 06/03/15 at 9:30 AM, revealed the base of a portable blood pressure machine was covered with brown dust-like particles.</p> <p>11. Observation of the 2B Unit, on 06/03/15 at 9:30 AM, revealed the thresholds of rooms #224, #225, #226, #228, #229, #230, #236, #237, #239, #241, #243, #245, #247, and #249, the Snack Room, and the entry way to 2B were not stripped of old wax and cleaned before new wax was applied to the floor leaving large areas of dirty wax. In addition, around the door frames and floors of these rooms, had a build-up of dark colored debris and dirt. Also, the metal kick plates attached to the doors were all scuffed, scrapped and had large black stains.</p> <p>Further observation of the 2B Nursing Station, on 06/03/15 at 9:30 AM, revealed the Snack Room door had a window that was streaked and was</p> | F 253         |   |                      |

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| F 253 | <p>Continued From page 10</p> <p>covered with tape residue. The microwave in the Snack Room was heavily soiled with a dried yellow substance with black scorched-like spots. The Janitor's closet door was covered with black ground-in substance and the threshold was soiled with black dried substances and debris. The Soiled Utility Room door had peeling paint, was heavily soiled with black and brown marks; and, the threshold was dark brown in color with ground-in dirt and black particles. The metal lower door guard was scuffed, scraped, and soiled. The entry to the 2B Unit from the 2C Unit had soiled areas around the door frame and on the door. Observation revealed the door frame had chipped paint, the floor had dark reddish stains scattered around the entry way.</p> <p>12. Observation of Unit 2B, on 06/04/15 at 11:13 AM, revealed room #223 had a dried, red substance stuck to the floor and fall strips with white, yellow, and pink particles. In addition, small pieces of foil wrapper paper were stuck to the floor strips and the floor corners and doorway thresholds had a black substance embedded in them. At 11:23 AM, room #225 (Resident #28) had a white film of powdery substance covering the entire surface of the furniture. In addition, the floor contained black smudge marks and a clear disposable glove was in the corner behind the door on the floor. At 11:27 AM, observation revealed room #229 had brown particles on the toilet ring surface when the toilet seat was lifted up, and the bathroom and door entryway threshold were covered with a black substance.</p> <p>13. Review of Unsampled Resident G's clinical record revealed the facility assessed the resident with a score of fifteen (15) of fifteen (15) on the</p> | F 253 |  |  |
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| F 253  | <p>Continued From page 11</p> <p>Brief Interview for Mental Status (BIMS), on 03/21/15, which meant the resident was interviewable.</p> <p>Observation of Unit 2B, on 06/04/15 at 2:36 PM, revealed in Unsamped Residents F and G's room (room #226), the area at the entrance to the bathroom was black and sticky. In addition, Unsamped Resident G's wheelchair wheels were sticky.</p> <p>Interview with Unsamped Resident G (room #226 Unit 2B), on 06/04/15 at 3:01 PM, revealed the resident wanted the room and bathroom cleaned and he/she expressed concern over the length of time the facility had been dirty. The resident stated no one was going to clean up the mess in the bedroom as there was no housekeeper on the unit on many days for the past several months. The resident stated many days he/she self-propelled to the bathroom through the black substance on the floor only to have the wheels on his/her chair become covered with the black sticky substance. Unsamped Resident G stated the substance would get on his/her hands and then he/she had black sticky hands. In addition, Unsamped Resident G stated Unsamped Resident F often missed the commode when voiding and urinated on the floor accidentally. Unsamped Resident G stated it was easy to roll the wheelchair right through the urine as the floor would not be mopped. The resident further stated it was disgusting to have to tolerate how the facility treated the residents. He/she stated his/her housekeeping concerns had been voiced to the Managers, but the infrequency of cleaning had gotten worse. The resident stated it was very embarrassing how the facility was unclean.</p> | F 253  |   |                      |  |

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| F 253  | <p>Continued From page 12</p> <p>14. Review of the Minimum Data Set, Brief Interview for Mental Status, revealed the facility assessed Resident #27 on 05/01/15 with a score of fifteen (15) of fifteen (15) which meant the resident was interviewable.</p> <p>Interview with Resident #27 (room #203 Unit 2C), on 06/02/15 at 1:21 PM, revealed he/she did not use the bathroom in his/her room because the toilet would be full of toilet paper and the paper towels would be strewn on the bathroom floor even after housekeeping had been in the room. Resident #27 stated he/she had to use the toilet in the shower room down the hall because of the mess in the bathroom.</p> <p>15. Interview with Licensed Practical Nurse (LPN) #7, on 06/03/15 at 10:10 AM, revealed Resident #19 (Room #136 Unit 1B) did not have a history of falls nor did the resident have a Physician's Order for fall mats. She stated the fall mat under the resident's bed would be ineffective even if it had been ordered as it was laying directly under the bed. LPN #7 stated she could see the debris on top of the mat and the black/brown dirt around the perimeter of the mat. She stated Resident #19 had lived in Room #136 for about a year and the fall mat had probably been used for the previous resident in that bed.</p> <p>16. Interview with Environmental Services (ES) #2, on 06/03/15 at 10:20 AM, revealed he had been sent to the facility from out-of-state just last week by the contracted housekeeping company to be a front line housekeeper. He stated he had six (6) employees on duty on 06/03/15 to clean eighty-eight (88) resident rooms and all other areas of the facility. He stated fall mats were</p> | F 253  |   |                      |  |

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| F 253  | <p>Continued From page 13</p> <p>supposed to be lifted up and moved and the top of the mat and the floor under the mat cleaned daily. ES #2 stated the fall mat under the bed in room #136 could not have been cleaned for quite a while, but it should have been.</p> <p>Interview with CNA #6, on 06/03/15 at 10:40 AM, revealed the Housekeeping Department had been short staffed and sometimes he would not see a housekeeper for days. She stated management expected the CNAs to help with cleaning, but they didn't have access to the brooms or mops because the door was locked.</p> <p>Interview with LPN #10, on 06/03/15 at 3:14 PM, revealed the facility had not had adequate housekeeping staff and the house keeping should have been more diligent.</p> <p>Interview with Housekeeper #1, on 06/04/15 at 9:34 AM, revealed housekeeping had been short staffed because staff and supervisors had been fired. He was hired to do the floors eight (8) months ago, but since the Housekeeping Department had been short-staffed he volunteered to help with cleaning.</p> <p>17. Observation of Unit 2B during the environmental tour with the Administrator and the Assistant Maintenance Director, on 06/04/15 at 4:40 PM, revealed approximately ten (10) feet of the wooden handrail was rough and splintered.</p> <p>Observation during the Extended Survey, on 06/17/15 at 3:13 PM, revealed approximately fourteen (14) feet of metal handrail loose from the wall and wobbly on the activities room corridor adjacent to Unit 1B.</p> <p>Interview with the Maintenance Director, on</p> | F 253  |   |                      |  |

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| F 253   | <p>Continued From page 14</p> <p>06/18/15 at 8:49 AM, revealed he had known for some time (no time specified) the metal handrail was loose from the wall and wobbly on the activities room corridor adjacent to Unit 1B. However, he stated a welder would have to be contracted to fix the railing and that had not been done. The Maintenance Director stated he knew the resident handrails were to be tight to prevent residents from falling.</p> <p>Interview with the Maintenance Assistant, on 06/04/15 at 5:14 PM, revealed he and the Maintenance Director made facility rounds every day, but they did not go into every resident's room or inspect every part of the building. He stated they did not document their rounds, but would note if they found maintenance concerns. The Maintenance Assistant explained there was a system for staff to give work orders to him and the Maintenance Director and when a repair had been completed the work order would be initialed by himself or the Maintenance Director and then the work orders would be kept in a stack in the maintenance office. He further stated he and the Maintenance Director were the only staff in the Maintenance Department.</p> <p>Interview with the Maintenance Director, on 06/04/15 at 5:20 PM, revealed he used a computer program to document preventive maintenance checks, but checking the building for loose handrails, needed painting or plasterwork, repairs of ice machines or other equipment would not be on that document. He stated sometimes he would report maintenance concerns verbally to the Administrator, but he could not patch and paint with everything else he had to do.</p> | F 253   |   |                      |   |

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| F 253 | <p>Continued From page 15</p> <p>Interview with the Administrator, on 06/04/15, at 5:41 PM, revealed concerns were made to the facility's ownership about his and residents' concerns regarding housekeeping for the past several months. He stated he knew the facility was not clean and the residents deserved to live in a clean environment. He further stated he made rounds of the facility every day, but he did not document any of his round findings. He stated he completed a monthly housekeeping survey which was scored and the scores were low, but he was not willing to provide copies of those documents. The Administrator stated the Maintenance Director was responsible for facility repairs and was required to report to him if there were major issues and that the only written report he reviewed from the Maintenance Department was a computer program about preventive maintenance. He stated the maintenance concerns noted during the environmental tour were not on the preventive maintenance program, but repairs were needed. The Administrator stated he was ultimately responsible for the facility and correcting problems at the facility.</p> <p>Observation during the Extended Survey, on 06/17/15 at 3:13 PM, revealed approximately fourteen (14) feet of metal handrail loose from the wall and wobbly on the activities room corridor adjacent to Unit 1B.</p> <p>Interview with the Maintenance Director, on 06/18/15 at 8:49 AM, revealed he had known for some time (no time specified) the metal handrail was loose from the wall and wobbly on the activities room corridor adjacent to Unit 1B. However, he stated a welder would have to be contracted to fix the railing and that had not been</p> | F 253 |  |  |
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| F 253  | Continued From page 16 done. The Maintenance Director stated he knew the resident handrails were to be tight to prevent residents from falling.   | F 253  |  |                      |  |
| F 280<br>SS=D  | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to review and revise the care plan for one (1) of thirty-two (32) sampled residents, (Resident #5) for continued refusal of daily cleaning of the room and/or assist the resident in decreasing clutter in the room. In | F 280  | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>On 6/5/15 Social Services Director met with Resident #5 and addressed the room clutter, hoarding behaviors and importance of safety awareness. The Activity Director and Social Services Director talked with the resident about storage for jewelry supplies and beads. Resident in agreement to store supplies in the Activity Room. A set of plastic drawers and 5 plastic containers of beads were moved to the activity room, where the resident can still access them. The residents care plan was updated to reflect this agreement and added as an additional intervention.<br>Nursing and Housekeeping staff was able to declutter and deep clean Resident#5's room on 6/5/15.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>Other residents that experience falls have the potential to be effected. Residents experiencing a fall within the last 30 days have had their care plan reviewed, by the DNS, ADNS and MDS Nurse, for appropriate interventions. Any Resident event that involves a fall is reviewed during the Daily Clinical Start Up meeting, attended by the DNS, ADNSs, MDS nurses and HIM (Health Information Manager). Resident care plans and current interventions are also reviewed during this |                      |  |

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| F 280  | <p>Continued From page 17</p> <p>addition, the facility failed to review and revise the care plan for Resident #5 after the resident had three (3) falls, one resulting in a fracture.</p> <p>The findings include:</p> <p>The facility did not provide a policy for care planning.</p> <p>Review of the facility's policy for Falls, not dated, revealed the purpose of the policy was to identify risks and establish interventions to mitigate the occurrences of falls. The fall event and interventions were recorded on the 24 hour report, resident care plan and CNA care card. Interventions identified were implemented. The Interdisciplinary Team reviews post fall investigations and summarizes the team recommendations for interventions.</p> <p>Review of the clinical record for Resident #5, revealed the facility admitted the resident on 12/05/11 with diagnoses of Ethanol (ETOH) Abuse, Major Depression and Anxiety.</p> <p>Review of the clinical record of Resident #5, revealed a quarterly Minimum Data Set (MDS) assessment, dated 04/16/15, that assessed the resident with a score of fifteen (15) of fifteen (15) on the Brief Interview for Mental Status (BIMS) meaning the resident was interviewable. The resident required extensive to limited assistance with activities of daily living. The facility documented the resident had no behaviors.</p> <p>Review of the comprehensive care plan, dated 07/28/11, with a target date of 12/23/14, for Resident #5, revealed the resident had a history of falls. Per the care plan, on 11/20/14, the</p> | F 280  | <p>meeting. The Post Fall evaluation is reviewed during the meeting to aid in identifying possible root cause and the care plan is reviewed for appropriate interventions and additional interventions are included at this time.</p> <p><b>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?</b><br/>On 6/5/15 Social Services Director met with Resident #5 and addressed the room clutter, hoarding behaviors and importance of safety awareness. The Activity Director and Social Services Director talked with the resident about storage for jewelry supplies and beads. Resident in agreement to store supplies in the Activity Room. A set of plastic drawers and 5 plastic containers of beads were moved to the activity room, where the resident can still access them. The residents care plan was updated to reflect this agreement and added as an additional intervention.</p> <p>Nursing and Housekeeping staff was able to declutter and deep clean Resident#5's room on 6/5/15.</p> <p>Housekeeping staff have been educated on reporting to the Charge Nurse, if the resident refuses to have room cleaned on a regular basis and the Charge Nurse and Social Services will discuss with the resident.</p> <p>During the Clinical Start Up meeting attended by the DNS, ADNSs', MDS nurse and the HIM (Health Information Manager) resident events are reviewed and those having a fall have the event and the post fall evaluation reviewed to assist in determining cause of a fall and to include any specific interventions to assist in preventing recurrence added to the care plan. The care plan interventions, related to fall prevention, are also reviewed at this time to assure they are relevant and revised as</p> |  |

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| F 280  | <p>Continued From page 18</p> <p>resident had a fall in the room and sustained a fractured left arm. On 01/06/15, the resident fell out of bed while reaching for something, with no injuries. The resident got dizzy and fell on 04/18/15 resulting in a laceration and a lump on the head. The resident tripped over the walker on 04/25/15 and fell to the floor with no injuries. On 05/02/15 the resident told a nurse about a fall and the resident had an abrasion on the left elbow. On 05/04/15 the resident was found on the floor in the doorway to the room after tripping over the walker and there were no injuries. There was no evidence the care plan was reviewed or revised for these falls as the target date remained 12/23/14 and no new interventions were added.</p> <p>Further review of the Comprehensive Care Plan for Resident #5, dated 07/28/11, revealed the resident's room frequently had an unkept appearance and since the resident made beaded jewelry, there were risks of injuries to the resident and staff from spilled beads on the floor. Housekeepers were to mop and clean the room daily. Social Services staff was to speak with the resident and explain the risk and benefits of containing the beads. Nursing staff were to attempt to tidy the room daily with the resident present. All staff was to encourage the resident to reduce clutter and obstacles in the path to the bathroom. The onset date of the problem was 07/28/11. There was no evidence to show the care plan was reviewed and revised in attempts to de-clutter and clean the resident's room to attempt to decrease falls and injuries.</p> <p>Observation of Resident #5, on 06/02/15 at 1:35 PM, 3:00 PM, 3:35 PM, on 06/03/15 at 8:23 AM, 9:15 AM, 10:40 AM and on 06/04/15 at 11:00 AM, revealed there were piles of clothing on the floor</p> | F 280  | <p>needed. The ADNSs' also make daily rounds focusing on fall prevention and safety interventions to maintain continued compliance.</p> <p>Resident Care Plans are reviewed during scheduled care plan reviews, according to the assessment schedule with the IDT, resident and / or responsible party. Care plans also reviewed and revised as needed during the Clinical Start Up meeting.</p> <p><b>How will the facility monitor performance to ensure solutions are sustained?</b><br/>Nursing staff has been educated by the Staff Development Coordinator on monitoring the resident rooms for safety awareness and compliance with care plan interventions to assist in preventing recurrence of resident falls 7/8/1. This education will also be included during new hire orientation and annually. The ADNSs' will continue their daily rounds focusing on fall prevention and safety interventions to monitor continued compliance. The DNS reviews the results of the ADNSs daily rounds that focus on resident safety during the monthly QAPI meeting, x 6 months. The QAPI meeting is attended by the Administrator, Medical Director, DNS and two or more of the following: ADNS, MDS Nurse, Dietary, Social Services, Activities, Housekeeping, Maintenance or Specialized Rehab Therapy for their review and any additional interventions that they recommend to maintain continued compliance.</p> | 7-22-15                                      |

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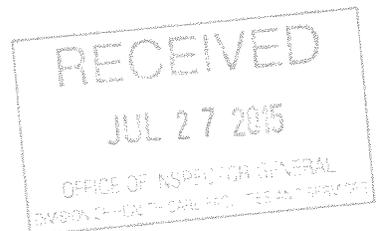
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| F 280  | <p>Continued From page 19</p> <p>and five (5) stuffed animals. Bottles of Sprite were on the floor. The nonskid strips on the floor by the resident's bed were torn and worn and coming up off the floor. There was an opened pudding container and an opened container of fruit salad on the floor. In the bathroom, there were resident clothes piled up on a walker and a bag of briefs was on the floor. All surfaces in the room were soiled with debris and sticky substances.</p> <p>Interview with Certified Nursing Assistant (CNA) #6, on 06/03/15 at 2:10 PM, revealed she usually left Resident #5 alone and she made no effort to encourage the resident to allow the room to be de-cluttered. She stated she was not aware of anyone attempting to clean the resident's room. She stated there were no new instructions on how to get the resident to allow staff to de-clutter the room and the current care plan did not work.</p> <p>Interview with Resident #5, on 06/03/15 at 2:10 PM, revealed the resident stated the facility rarely asked him/her about cleaning the room to remove some of the clutter, and everyone just left him/her alone.</p> <p>Interview with Licensed Practical Nurse (LPN) #11, on 06/03/15 at 2:51 PM, revealed Resident #5's care plan was not working because the resident was still falling and the room was still cluttered. She stated the resident often tripped over objects in the room while trying to get to the bathroom and there were no new interventions in place to prevent further falls or to ensure the resident's room was de-cluttered.</p> <p>Interview with LPN #10, on 06/03/15 at 2:51 PM, revealed Resident #5's care plan was not working</p> | F 280  |   |  |

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| F 280  | Continued From page 20<br>and the resident fell. He stated the nurses were responsible to update the care plan with new orders and interventions as needed, with falls included. He stated Resident #5 was noncompliant and they could not think of anything else to do to prevent falls as the resident wanted to be independent; however, the resident's gait was unsteady.<br><br>Interview with the Social Service Worker, on 06/04/15 at 3:40 PM, revealed she had asked Resident #5 if staff could clean his/her room to remove some of the clutter and the resident stated no. She stated further that the resident had the right to their preferences and so the care plan was never revised. She stated the resident would let her know when de-cluttering could occur, so the care plan was on hold. She stated she did not realize the resident was hoarding and that the care plan should be revised when interventions were unsuccessful.<br><br>Interview with the Administrator, on 06/04/15 at 4:05 PM, revealed he was the supervisor for the Social Services staff. He stated he had not given any directives to the Social Services Worker to try to care plan and resolve the situation with Resident #5's room. He stated he had never considered Resident #5's room as a problem; however, he could see there was little room for the resident's roommate and wheelchair. | F 280  |  |  |
| F 282<br>SS=D  | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  | F 282  | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The Charge Nurse for Resident #1, notified the physician and the responsible party that the palm guard had not been applied per the care plan for 3 days. The palm guard was replaced and placed on Resident #1 on the afternoon of 6/4/15 and removed at bedtime. |  |



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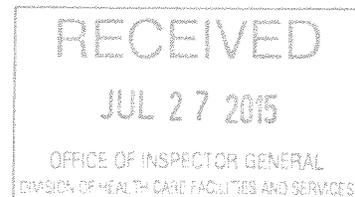
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| F 282 | Continued From page 21<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI) User Manual 3.0, it was determined the facility failed to implement care plan interventions for one (1) of thirty-two (32) sampled residents (Resident #1). The staff failed to apply a palm guard to Resident #1's hand per the plan of care.<br><br>The findings include:<br><br>The facility did not provide a policy on following the care plan. Interview with the Administrator, on 06/11/15 at 1:42 PM, revealed the facility utilized the Resident Assessment Instrument (RAI) 3.0 guidelines for the care plan process.<br><br>Review of the Resident Assessment Instrument (RAI) User Manual 3.0, dated 2010, revealed the comprehensive care plan was an interdisciplinary communication tool and interventions were to be selected and implemented that addressed the individual's physical, functional, and psychosocial needs, concerns, problems and risks.<br><br>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 02/06/15 with diagnoses of Senile Dementia, Failure to Thrive, Esophageal Reflux, Peptic Ulcer, Gastro Paresis, Hypertension, and Diaphragmatic Hernia.<br><br>Review, of the Occupational Therapy Assessment for Resident #1, dated 02/06/15, revealed the resident was assessed to have left hand/digit | F 282 | How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>Physician orders for all other residents have been reviewed by the DNS and ADNSs for those residents with orders for splints or palm guards. The ADNSs reviewed all of the CNA care guides/assignment sheets on 6/5/15 to assure that the palm guards were included for each of the residents with orders for palm guards. On 6/5/15 the DNS and ADNSs also visually checked each resident with an order for a palm guard to assure that the guard was in place, as ordered. Placement of ordered palm guards are checked during daily Licensed Staff rounds and during the ADNSs daily rounds to assure that palm guards are in place as ordered.<br><br>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?<br>Residents with new orders for palm guards/splints are reviewed during the Daily Clinical Start-Up meeting attended by the DNS, ADNSs', MDS nurses and the HIM (Health Information Manager). The care plans for those residents will be reviewed and updated to include the palm guards during this meeting. The ADNSs will review the CNA care guides/assignment sheets to assure that the interventions are included. Licensed Staff and ADNSs will assure that palm guards are utilized as ordered daily during their unit rounds and will follow up on any deviation with the staff assigned to the affected resident. To maintain continued compliance, licensed staff have been re-educated on following MD orders and following care plans by the ADNS, SDC or DNS on 6/4/15. |  |
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| F 282  | <p>Continued From page 22</p> <p>flexion contracture on the middle and ring fingers, and needed splinting or a palm guard to protect skin and for hygiene.</p> <p>Review of current physician orders for Resident #1 revealed the physician ordered a palm protector (on 02/06/15) for daily placement on the resident's left hand. The palm guard was to be placed on the resident's left hand in the morning, with removal of the device at bedtime.</p> <p>Review of the Minimum Data Set (MDS) Assessment for Resident #1, dated 02/16/15, revealed the facility assessed Resident #1 with contractures of both hands. Review of the functional assessment within the MDS revealed the facility assessed Resident #1 with upper extremity impairment on one side of his/her body and triggered for extensive assistance with Activities of Daily Living (ADLs). In addition, the Care Area Assessment (CAA) Summary revealed Resident #1 triggered as being at risk for the development of pressure ulcers.</p> <p>Review of Resident #1's care plan, dated 02/26/15, for the prevention of skin breakdown revealed Resident #1 had a contracture of his/her left hand that required a brace (palm guard) for placement on the resident's left hand in the morning and was to be removed at bedtime.</p> <p>Review of the Certified Nursing Assistant (CNA) Assignment Sheet for Resident #1 did not reveal any information about Resident #1's palm guard, yet other residents listed on the assignment sheet had instructions for special needs/devices listed under Other Special Needs and Instructions.</p> <p>Observation, on 06/02/15 at 2:35 PM and 4:34 PM, on 06/03/15 at 8:40 AM, 9:16 AM, and 10:35</p> | F 282  | <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>Licensed staff education will be included during new hire orientation and annually. Care Plans are reviewed on admission, annually, quarterly and when there is a significant change in the residents' condition. This care plan review will monitor for continued compliance while reviewing the residents that have palm guards. To maintain continued compliance, the ADNSs' will monitor the application of the palm guards during their unit rounds. Unit walking rounds completed by the ADNSs are made several times throughout their work day. If an issue is identified, the ADNS will provided immediate 1:1 re-education with the staff member and assure placement of the palm guard. The DNS reviews the results of the ADNSs daily rounds, identifying any pattern or trend daily and will review their findings during the monthly QAPI meeting which is attended by the Administrator, Medical Director, DNS and two or more of the following: ADNS, MDS Nurse, Dietary, Social Services, Activities, Housekeeping, Maintenance or Specialized Rehab Therapy x 6 months for their review and any additional interventions or suggestions that they recommend to maintain continued compliance.</p> | 7-22-15              |  |

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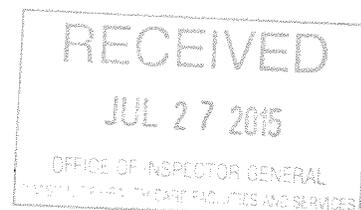
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| F 282  | <p>Continued From page 23</p> <p>AM, and on 06/04/15 at 10:00 AM, revealed the resident's hands were contracted, the left hand remained closed in a fist-like position, and there was no palm guard on the left hand.</p> <p>Interview, on 06/04/15 at 11:30 AM, with CNA #4 revealed she had not placed the palm guard on Resident #1 in the past. CNA #4 stated Resident #1's palm guard had been missing since Monday (06/01/15) and she reported it to the unit nurse. CNA #4 stated she would normally find information on her copy of the CNA Assignment Sheet about special instructions for care and any splints or devices the residents needed, but she had not seen any information about Resident #1's palm guard on that document.</p> <p>Interview, on 06/04/15 at 10:35 AM, with Licensed Practical Nurse (LPN) #1, revealed she first noticed Resident #1's palm guard was missing on 06/01/15 and Resident #1 had not had the palm guard on for the past three (3) days because it could not be found. LPN #1 stated the licensed nurse was responsible for ensuring the palm guard was applied to the resident's left hand, but the CNA assigned to the resident may also ensure the palm guard was available and could apply it. LPN #1 stated the palm guard should be listed on the CNA's assignment sheet under Resident #1's name, and this should alert the CNA that the device was to be available for use. LPN #1 stated Resident #1's left hand contracture was pretty severe and that the resident tended to fight/resist placement of the palm guard; however, staff should apply the palm guard as ordered and care planned.</p> <p>Interview, on 06/04/15 at 3:40 PM, with the Director of Nursing (DON) revealed Resident #1</p> | F 282  |   |                      |  |

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| F 282  | Continued From page 24<br>should have had the palm guard applied as care planned. The DON stated if the palm guard was not applied as ordered and care planned, the resident would have an increased risk for skin breakdown.   | F 282  |   |  |
| F 309<br>SS=D  | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined the facility failed to provide care and services, per the resident's plan of care, for one (1) of thirty-two (32) sampled residents (Resident #1). The physician ordered a palm guard to be applied daily to Resident #1's hand and the facility care planned for the staff to apply the palm guard to the hand; however the staff failed to apply the palm guard for three (3) days, 06/02/15, 06/03/15, and 06/04/15.<br><br>The findings include:<br><br>The facility did not provide a policy regarding the application of palm guards/splints.<br><br>Review of the clinical record for Resident #1 revealed the facility admitted the resident on | F 309  | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>The Charge Nurse for Resident #1, notified the physician and the responsible party that the palm guard had not been applied per the care plan for 3 days. The palm guard was replaced and placed on Resident #1 on the afternoon of 6/4/15 and removed at bedtime as ordered.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>Physician orders for all other residents have been reviewed by the DNS and ADNSSs for those residents with orders for splints or palm guards. The ADNSSs reviewed all of the CNA care guides/assignment sheets on 6/5/15 to assure that the palm guards were included for each of the residents with orders for palm guards. . On 6/5/15 the DNS and ADNSSs also visually checked each resident with an order for a palm guard to assure that the guard was in place, as ordered. Placement of ordered palm guards are checked during daily Licensed Staff rounds and during the ADNSSs daily rounds to assure that palm guards are in place as ordered. |  |



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| F 309              | <p>Continued From page 25</p> <p>02/06/15 with diagnoses of Senile Dementia, Failure to Thrive, Esophageal Reflux, Peptic Ulcer, Gastro Paresis, Hypertension, and Diaphragmatic Hernia.</p> <p>Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 02/16/15, revealed the facility assessed the resident with contractures of both hands. Resident #1's MDS functional assessment revealed he/she had upper extremity impairment on one side of the body and the resident triggered for extensive assistance with his/her Activities of Daily Living (ADLs). In addition, review of the MDS Care Area Assessment (CAA) Summary revealed Resident #1 triggered at risk for the development of pressure ulcers.</p> <p>Review of the Occupational Therapy Assessment for Resident #1, dated 02/06/15, revealed the resident was assessed to have left hand/digit flexion contracture on the middle and ring fingers and needed splinting or a palm guard to protect skin and for hygiene.</p> <p>Review of Resident #1's physician orders, dated 02/06/15, revealed a palm guard was to be placed on the resident's left hand daily in the morning with removal of the device at bedtime.</p> <p>Review of Resident #1's care plan for the prevention of skin breakdown, dated 02/26/15 with a goal date of 08/18/15, revealed Resident #1 had a contracture of his/her left hand that required a brace (palm guard) for placement on the resident's left hand in the morning and it was to be removed at bedtime. An intervention dated 02/10/15 stated a "palm guard to left hand in AM and off PM". However, review of the Certified</p> | F 309         | <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur</p> <p>Residents with new orders for palm guards/splints are reviewed during the Daily Clinical Start Up meeting attended by the DNS, ADNNSs, MDS nurses and the HIM (Health Information Manager). The care plans for those residents will be reviewed and updated to include the palm guards during this meeting. The ADNNSs will review the CNA care guides/assignment sheets to assure that the interventions are included. Licensed Staff and ADNNSs will assure that palm guards are utilized as ordered daily during their unit rounds and will follow up on any deviation with the staff assigned to the affected resident. To maintain continued compliance, licensed staff have been re-educated on following MD orders and following care plan interventions by the ADNS, SDC or DNS on 6/4/15.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>Licensed staff education will be included during new hire orientation and annually. Care Plans are reviewed on admission, annually, quarterly and when there is a significant change in the residents' condition. This care plan review will monitor for continued compliance while reviewing the residents that have palm guards. To maintain continued compliance, the ADNNSs will monitor the application of the palm guards during their unit rounds. If an issue is identified, the ADNS will provided immediate 1:1 re-education with the staff member and assure placement of the palm guard. The DNS reviews the results of the ADNNSs daily rounds, identifying any pattern or trend daily and will review their findings during the monthly QAPI meeting</p> |                      |

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| F 309  | <p>Continued From page 26</p> <p>Nursing Assistant (CNA) Assignment Sheet for Resident #1 revealed no information related to application of Resident #1's palm guard.</p> <p>Observation, on 06/02/15 at 2:35 PM, revealed Resident #1 did not have a palm guard on his/her left hand which was closed in a fist-like position. At 4:34 PM, revealed Resident #1 did not have a palm guard on the left hand.</p> <p>Observation, on 06/03/15 at 8:40 AM, revealed both of Resident #1's hands were contracted and there was no palm guard on the left hand. At 9:16 AM, Resident #1 did not have a palm guard on his/her left hand. Continued observation, at 9:22 AM, revealed Resident #1 did not have the palm guard on his/her left hand and the hand remained curled into a fist-like position. Additional observation, at 10:35 AM, revealed Resident #1 did not have a palm guard on his/her left hand. At 2:30 PM, Resident #1 did not have a palm guard on his/her left hand.</p> <p>Observation, on 06/04/15 at 10:00 AM, revealed Resident #1 did not have a palm guard on his/her left hand.</p> <p>Interview, on 06/03/15 at 11:00 AM, with the Occupational Therapist (OT), revealed Resident #1's hand contractures were significant on admission. The OT stated Resident #1 utilized the palm guard at another facility and brought it with them on admission. The OT stated due to the severity of the resident's contractures on admission, the Therapy Department recommended continued use of the palm guard with a goal to protect the resident from skin breakdown.</p> | F 309  | <p>which is attended by the Administrator, Medical Director, DNS and two or more of the following: ADNS, MDS Nurse, Dietary, Social Services, Activities, Housekeeping, Maintenance or Specialized Rehab Therapy x 6 months for their review and any additional interventions or suggestions that they recommend to maintain continued compliance.</p> | 7-22-15                                      |

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| F 309  | <p>Continued From page 27</p> <p>Interview, on 06/04/15 at 11:30 AM, with CNA #4 revealed she was routinely assigned to care for Resident #1; however she had not placed the palm guard on the resident. CNA #4 stated she reported to LPN #1 that the palm guard had been missing since Monday (06/01/15). CNA #4 stated they did not find the palm guard when she and the nurse searched the resident's room. CNA #4 stated she would normally find information on her copy of the CNA assignment sheet for special instructions for care and any splints or devices the resident needed. However, she had not seen any information about Resident #1's palm guard on the sheet. CNA #4 stated the palm guard could have been accidentally sent to the laundry services with the resident's soiled linen. CNA #4 stated LPN #1 told her a replacement palm guard had been ordered when she reported to her again the palm guard was not on the resident on 06/03/15.</p> <p>Interview, on 06/04/15 at 10:35 AM, with Licensed Practical Nurse (LPN) #1 revealed she searched the resident's room for the palm guard, but it was not found after she noticed Resident #1's palm guard was missing on 06/01/15. LPN #1 stated Resident #1 had not had the palm guard on over the past three (3) days because it could not be found. LPN #1 stated on 06/03/15 she notified the Occupational Therapist that Resident #1 needed a replacement palm guard.</p> <p>LPN #1 stated Resident #1's palm guard was ordered due to contractures for daily application to his/her left hand. LPN #1 stated the licensed nurse was responsible for ensuring the palm guard was placed, but the CNA assigned to the resident could also ensure the palm guard was available and could apply it if properly trained.</p> | F 309  |   |                      |  |

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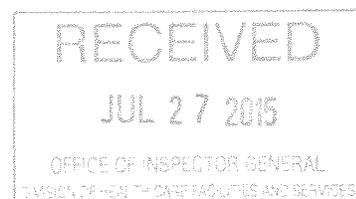
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| F 309  | <p>Continued From page 28</p> <p>LPN #1 stated the palm guard should be listed under Resident #1's name on the CNA assignment sheet to alert the CNA the device should be in the resident's room and available for use. LPN #1 stated Resident #1 tended to fight/resist placement of the palm guard because the left hand contracture was pretty severe. However, the staff should apply the palm guard as ordered and care planned.</p> <p>Interview, on 06/04/15 at 10:53 AM, with the Certified Occupational Therapist Assistant (COTA), revealed she ordered the guard when LPN #1 notified her on 06/03/15 of the need for a new palm guard for Resident #1. The COTA stated she could not find the palm guard during the search of the resident's room. The COTA stated she obtained a new palm guard and placed it on Resident #1's left hand about 2:00 PM on 06/03/15. The COTA stated that new palm guards were kept in the Therapy Department.</p> <p>Interview, on 06/04/15 at 3:40 PM, with the Director of Nursing (DON), revealed Resident #1 should have had the palm guard applied as ordered and care planned. The DON stated LPN #1 should have listed Resident #1's need for a new palm guard in the therapy department communication book on Monday (06/01/15), as soon as the staff became aware the palm guard was missing. The DON stated LPN #1 should have listed Resident #1's need for a new palm guard in the therapy department communication book. Per the DON if the palm guard was not applied as ordered and care planned, and if Resident #1's finger nails were not monitored for length and cleanliness, the resident would have an increased risk for skin breakdown.</p> | F 309  |   |  |

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| F 323<br>F 323<br>SS=0   | Continued From page 29<br>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, review of the facility's Fall Guidelines, and Post Fall Reports, it was determined the facility failed to ensure one (1) of thirty-two (32) sampled residents (Resident #5) had environmental hazards and risk factors for falls identified and interventions, including supervision, put into place to reduce falls. The facility failed to determine the causal factors for falls and monitor interventions for effectiveness. This failure resulted in Resident #5 continuing to fall. In addition, the facility failed to complete investigations of falls that occurred on 11/20/14 and 04/18/15.<br><br>The findings include:<br><br>Review of the facility's fall guide lines, not dated, revealed the purpose of the policy was to identify risk and establish interventions to mitigate the occurrence of falls. Post fall the resident is physically assessed for injuries and medical attention is rendered as needed. The physician and responsible party are notified of the fall. A fall "huddle" is called to help in investigating circumstances around the fall. The investigation | F 323<br>F 323   | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>On 6/5/15 Social Services Director met with Resident #5 and addressed the room clutter, hoarding behaviors and importance of safety awareness. The Activity Director and Social Services Director talked with the resident about storage for jewelry supplies and beads. Resident in agreement to store supplies in the Activity Room. A set of plastic drawers and 5 plastic containers of beads were moved to the activity room, where the resident can still access them. Social Services and Nursing assisted the resident in organizing their personal items to aid in removing potential hazards. Personal items were removed from the floor and placed in dresser, closet or bedside stand. Resident #5 has now allowed their room to be cleaned daily and it is monitored daily by the ADNS on their daily rounds, monitoring for possible safety/fall risks and resolving any issue that is noted at that time. The Care Plan for resident #5 has been updated to include that their craft supplies have been relocated to the activities room, that the room is monitored daily for possible fall risks related to placement of personal items and immediate resolution. Resident #5 has not experienced a fall in their room since 5/4/15. |  |



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| F 323 | <p>Continued From page 30</p> <p>included information to assist in choosing interventions to prevent further falls. The fall event and intervention is recorded on the 24 hour report, resident care plan and CNA care card. Interventions identified are to be implemented, and the IDT reviews post fall investigation and summarizes the team recommendations for interventions.</p> <p>Observations, on 06/02/15 at 8:30 AM, revealed extra furniture in the resident's room, all flat surfaces on the resident's side of the room were covered with personal items, stacks of boxes were on the floor, plastic containers were on the floor, non-skid strips on the floor next to the bed were torn partially away from the floor, blankets and pillows, newspapers, stuffed animals, and an open fruit cup were on the floor</p> <p>Review of the clinical record for Resident #5, revealed the facility admitted the resident with diagnoses of Major Depression, Anxiety and a history of Ethanol (ETOH) Abuse. The Quarterly Minimum Data Set (MDS) assessment for Resident #5, dated 04/16/15, revealed the facility assessed the resident with a score of fifteen (15) of fifteen (15) on the Brief Interview for Mental Status (BIMS) meaning the resident was interviewable. The facility further assessed the resident as requiring extensive to limited assistance with daily living and having poor vision corrected with contact lens or glasses. The resident had no behaviors or moods and was incontinent of bladder at times. The facility assessed the resident as requiring one person physical assist and supervision while walking with a rolling walker.</p> <p>Review of the Care Plan, dated 07/08/11, for</p> | F 323 | <p><b>How will the facility identify other residents having the potential to be affected by the same deficient practice?</b></p> <p>All risk evaluations are completed as part of the admission process, by licensed nurses, on all residents. As a proactive measure those residents identified as being at risk will have appropriate interventions included in their care initial plan. During the Daily Clinical Start Up meeting, attended by the DNS, ADNSs', MDS nurse and HIM, the Admission Clinical Health Assessment is reviewed for completion and review of any identified risk areas. Initial care plans are also reviewed to assure that interventions for identified risks are included. All resident events are reviewed during the Daily Clinical meeting. The event is reviewed including the specifics of the event and the possible cause. The resident care plan is discussed and interventions included or updated to assist in preventing recurrence. The ADNSs and DNS have re-reviewed all resident falls since 6/5/15 assuring that Post Fall evaluations have been completed including possible root cause and that care plan interventions have been reviewed and updated when necessary.</p> <p><b>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur</b></p> <p>To maintain continued compliance, during the Daily Clinical meeting, attended by the DNS, ADNS, MDS Nurse and HIM, all resident events are reviewed including falls, the Post Fall evaluations are reviewed in detail to</p> |  |
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| F 323  | <p>Continued From page 31</p> <p>Resident #5, revealed there were numerous environmental hazards within the resident's room. The facility identified numerous open containers of craft beads and beads were observed on the floor, frequently unkept room, piled up clothing, and a history of tripping over the wheels of the rolling walker. There was no evidence that the facility identified other environmental hazards such as the resident's hoarding behaviors as risk factors for falls.</p> <p>Review of the Post Fall Report for Resident #5, dated 10/14/14, revealed the resident fell while walking in the room at 7:20 AM with discomfort in area of trauma (not specified). The resident was determined to have impaired safety awareness and the resident's room was cluttered with personal belongings and craft supplies. There was no information on the report to explain how the resident fell or what caused the fall. The facility recommended the resident receive verbal cues and reminders; however, there were no recommendations to address the clutter in the resident's room to prevent another fall. There was an entry on the care plan dated 10/20/14, six (6) days after the fall, documenting a one-half bed rail on the right side of the bed to assist with bed mobility. There was no evidence the facility identified the root cause of the fall, ensured interventions minimized the factors causing the fall, ensured interventions were correctly and consistently followed or that the facility initiated an immediate intervention to prevent further falls.</p> <p>The Post Fall Report for Resident #5's fall on 11/20/14 while walking in the room, was not provided by the facility. The resident sustained a fractured arm during that fall. Review of the care plan revealed no new interventions were added</p> | F 323  | <p>identify the possible root cause of the fall. The DNS or ADNS will follow up on any Post Fall Evaluations that are noted to be incomplete with the appropriate staff member and will review them in the next Daily Clinical meeting. The MDS Nurse will review the current care plan interventions with the team and the team will formulate other interventions to assist in preventing further falls.</p> <p>How will the facility monitor performance to ensure solutions are sustained?<br/>During the monthly center QAPI meeting, attended by the Administrator, Medical Director, DNS and two or more of the following: ADNS, MDS Nurse, Dietary, Social Services, Activities, Maintenance, Housekeeping or Specialized Rehab Therapy. The DNS will present all events/falls and identified root causes including any patterns or trends identified. Specific resident interventions may be reviewed for QAPI members input for possible additional interventions and review to prevent recurrence and maintain compliance. This review and information will be presented at the monthly QAPI meeting. To maintain continued compliance this is standard meeting agenda item to be reviewed during the Monthly QAPI meeting.</p> | 11-22-15             |  |

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| F 323  | <p>Continued From page 32 after the fall with fracture.</p> <p>Review of the Post Fall Report for Resident #5, dated 01/06/15, revealed Resident #5 had a history of falls and the resident's room continued to be cluttered with personal belongings and craft supplies. The resident leaned forward from the wheelchair and slid from the chair to the floor without injury. The resident was doing usual activities according to the report. There was no evidence of any safety interventions that were in place prior to the fall. The resident was receiving therapy at the time of the fall. There was no evidence the facility determined the root cause of the fall.</p> <p>Review of the Care Plan, not dated, for Resident #5, revealed no evidence the care plan was revised to minimize or resolve the causal factor with no interventions to prevent another fall.</p> <p>Review of the Care Plan, not dated, for Resident #5, revealed the resident was found sitting on the floor on 04/18/15 after exiting the Snack Room sustaining a laceration and swelling to the top of the head without mention of any treatment required.</p> <p>A Post Fall Report for Resident #5 for the fall, dated 04/18/15, was not provided by the facility.</p> <p>Review of the Care Plan for Resident #5, revealed a urinalysis was obtained on 04/18/15 to check for a Urinary Tract Infection. There was no evidence the facility determined the root cause of the fall or initiated an immediate intervention to prevent another fall.</p> | F 323  |   |                      |  |

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| F 323  | <p>Continued From page 33</p> <p>Review of the Post Fall Report, dated 05/02/15, revealed Resident #5 had numerous falls in the past and fell while walking in the hallway. The resident sustained an abrasion on the left elbow. There was no evidence the facility determined the root cause of the fall.</p> <p>Review of the Care Plan for Resident #5, revealed no evidence the facility implemented immediate interventions to prevent further falls after the fall on 05/02/15.</p> <p>Further review of the Care Plan for Resident #5, revealed the resident was found on the floor, on 05/04/15 at 12:30 PM. A hand written statement revealed the resident stated he/she tripped over the back wheels of the walker and fell to the floor in his/her room. There was no evidence the facility determined the root cause of the fall or added an immediate intervention to prevent further falls.</p> <p>Review of the Post Fall Report, dated 05/04/15, revealed the resident had a fall on 05/04/15 at 12:30 PM, was walking in the room; however, did not identify the cause of the fall, or any interventions that were to be put in place on the care plan.</p> <p>Interview with Resident #5, on 06/02/15 at 4:56 PM, revealed the resident was told by Social Services that no staff person could try to unclutter his/her room without his/her permission. The resident stated no one was allowed to touch his/her property per Social Services directions. The resident stated there were falls from tripping over items in the room; however, no one was allowed to move anything. He/she stated all the objects blocking the floor were needed and the</p> | F 323  |   |  |

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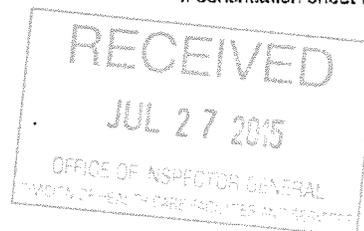
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| F 323  | <p>Continued From page 34</p> <p>roommate did not walk or talk. The resident stated he/she was not going to talk about the room anymore.</p> <p>Interview with Certified Nurse Aide (CNA) #6, on 06/03/15 at 2:30 PM, revealed Resident #5 had frequent falls and once broke an arm. The residents were supervised every two (2) hours when rounds were made by the CNA. She stated Resident #5 did not need too much help except for bathing and the resident did need supervision when out walking. She said the resident had falls while walking in the room and could be difficult and irritated if staff offered too many cues. She stated she was not aware of anything she was supposed to do to prevent the resident from falling, except make sure the resident used the rolling walker. She stated the resident collected everything and the floor space was so full that housekeeping could not sweep or mop the floor.</p> <p>Interview with Licensed Practical Nurse (LPN) #11, on 06/03/15 at 2:51 PM, revealed Resident #5's care plan was not working. LPN #11 stated the resident's room had little floor space and every surface was full of food, and paper products.</p> <p>Interview, on 06/04/15 at 11:40 PM, with the DON revealed she was responsible for investigating falls and completing the fall reports.</p> <p>Post survey interview with the Director of Nursing (DON), on 06/30/15 at 2:14 PM, revealed all falls were reported to the DON and documented on the 24 hour report. She stated she interviewed the staff present when the resident falls and read that Resident #5 was tripping in the room while using the walker. She stated the room was filled</p> | F 323  |   |                      |  |

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| F 323  | Continued From page 35<br>with furniture and boxes. In addition, she stated the resident wore long gowns and robes which were trip hazards. She stated the facility did not have a falls policy, but rather a falls guideline. She stated she completed all fall investigations including the cause of the fall. She stated she also looked at each fall for signs of abuse and neglect. She stated determining the root cause of falls was relaying what the resident did to cause themselves to fall.   | F 323  |  |  |
| F 364<br>SS=E  | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and policy review, it was determined the facility failed to ensure food served was palatable for two (2) of two (2) meals observed. Observation of the lunch meal on 06/03/15, revealed Dietary served tossed salad with no dressing and on 06/04/15, the lunch meal consisted of fried chicken meat that was dry, burned and hard to chew. In addition, two (2) of thirty-two (32) sample residents (Residents #4, #5) and three (3) of nine (9) unsampled residents (Unsampled Residents E, F and G) voiced dissatisfaction with the food being palatable.<br><br>The findings include: | F 364  | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>The Dietary Services Manager has met with resident #4, #5, E, F and G to review and address their concerns with food service by 7/10/15. Their food preferences have been updated at that time, as well.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All residents having meals served have the potential to be affected.<br><br>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur.<br>Resident food preferences will continue to be honored. The Dietary Services Manager will continue to attend the Resident Council meeting, when invited, to address any meal / food concerns and the Resident Choice Meal will continue to be chosen during Resident Council. As an additional avenue for resident review and input, the Dietary Services Manager and Activity Director will have a Resident Food Committee meeting, attended |  |



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| F 364 | <p>Continued From page 36</p> <p>Review of the Philosophy and Policy on Nutrition, effective 08/01/12, revealed the residents would be served attractive and tasty food.</p> <p>Interview with the Resident Council, on 06/02/15 at 3:00 PM, revealed Resident #5 (whom the facility assessed with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15) meaning the resident was interviewable) stated the food was occasionally good, they may have one (1) good meal and four (4) to five (5) days of bad meals. The food flavor and appearance was generally not satisfactory and generally cold. Unsampld Resident E (whom the facility assessed with a BIMS score of fifteen (15) of fifteen (15) meaning the resident was interviewable), stated he/she had never eaten so many peanut butter and jelly sandwiches in his/her lifetime because the food in the facility was so bad.</p> <p>During the Quality of Life Interview, on 06/02/2015 at 4:43 PM, with Resident #4, whom the facility assessed with a BIMS score of fifteen (15) of fifteen (15) meaning the resident was interviewable, the resident stated the food was not good. Resident #4 stated food served was frequently too salty for his/her taste or not seasoned at all and the meat was frequently tough. Resident #4 also stated that at times no meat was served.</p> <p>Observation of the lunch Meal, on 06/03/15 at 11:25 AM, revealed circular mini frozen pizzas, tossed salad, bread sticks and marinara sauce were served for the meal. No salad dressing was provided for the salad.</p> <p>Interview with Unsampled Resident F, on</p> | F 364 | <p>by residents, every month that will review menus and provide input. Residents # 4, #5, E, F and G will be invited and encouraged to attend the monthly Food Committee Meeting and provide their input. Test trays will be monitored by the Dietary Services Manager 3 times weekly, checking food palatability and temperature.</p> <p>The Dietary Services Manager has re-educated the cooks on following the recipes, along with cooking and holding times and temperatures on 6/11/15.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance the Dietary Services Manager will attend the Monthly Resident Food Committee meeting. Test trays will be monitored by the Dietary Services Manager 3 times weekly, checking food palatability and temperature. The results of the test tray monitoring will be brought to the monthly QAPI meeting by the Dietary Services Manager. The Dietary Services Manager will review the results with the QAPI team members. The education on following the recipes, cooking times, holding times and temperatures will be included in the new hire orientation for cooks and annually. Resident food concerns from Resident Council and suggestions from the monthly Resident Food committee and test tray audits will be reviewed in the monthly QAPI meeting attended by: Administrator, Medical Director, DNS and two or more of the following: ADNS, MDS Nurse, Dietary, Social Services, Activities, Maintenance, Housekeeping or</p> |  |
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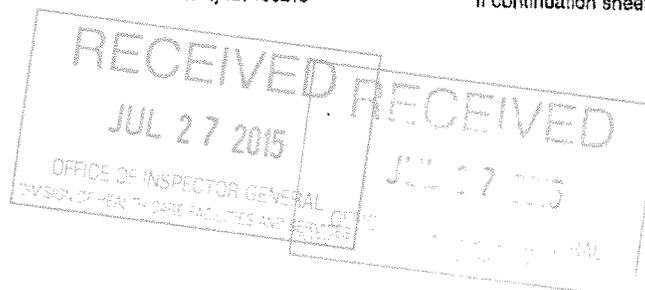
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| F 364 | <p>Continued From page 37</p> <p>06/03/15 at 2:46 PM, revealed the resident did not like the food served. The meat was tough and could hardly be chewed at times, especially the chicken and pork. The green beans had no flavor and everything tasted like it was dumped out of a can. The resident stated a sandwich could be obtained, but usually just bologna or cheese.</p> <p>Interview with Unsampled Resident G, on 06/03/15 at 2:59 PM, revealed the resident thought the food at the facility tasted terrible. The resident stated breakfast was not as bad as the other meals. The resident stated they could get a sandwich, but we can't get a home cooked meal and it was doubtful if there was any cooking done in the kitchen.</p> <p>Observation of the lunch meal, on 06/04/15 at 12:40 PM, revealed it consisted of stewed tomatoes, scalloped potatoes, mashed potatoes, fried chicken and gravy.</p> <p>Observations of the Test Tray, on 06/04/15 at 12:40 PM, revealed the chicken was dark brown, tough, and difficult to cut. The temperature was retaken and tested at 102 degrees Fahrenheit (F), the temperature of the scalloped potatoes tested at 109 degrees (F) and tasted salty, and the temperature of the tomatoes tested at 104 degrees (F). A sample tasting of the test tray at this time revealed the stewed tomatoes on the plate were sharply acidic and burned when eaten. The scalloped potatoes on the plate were very salty, had an unpleasant taste of powdered cheese and were luke-warm when tasted.</p> <p>Interview with the Dietary Manager, on 06/04/15 at 12:40 PM, revealed he had no concerns with the food that was served on the Test Tray.</p> | F 364 | <p>Specialized Rehab Therapy for additional recommendations that address resident food concerns. To maintain continued compliance the results and review of the Resident Council and the Food Committee suggestions will be a standard meeting agenda item to be reviewed during the Monthly QAPI meeting to maintain continued compliance.</p> | 7-22-15 |
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| F 364  | Continued From page 38<br><br>Interview with Cook #1, on 06/04/15 at 4:04 PM, revealed she had heard complaints about the food from the residents, such as there was no seasoning, the chicken was burnt and they could not chew the food. Cook #1 stated the Dietary Manager was aware, but told her to serve the food anyway.<br><br>Further interview with the Dietary Manager, on 06/04/15 at 4:40 PM, revealed the chicken was tough and hard to cut. He stated the chicken was pre-cooked when delivered from the vendor and they just had to reheat it.   | F 364  |  |  |
| F 371<br>SS=J  | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, review of the Centers' for Disease Control and Prevention document and facility policy, it was determined the facility failed to ensure food was stored, prepared, and served under sanitary conditions. The facility failed to ensure the kitchen was free of pest and mice droppings on the floor of the dry | F 371  | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>On 6/5/15 the Pest Control Company was at the center and inspected the dry storage area in the kitchen. The dry storage area of the kitchen was completely cleaned by kitchen staff on 6/6/15. Staff has been educated by the Dietary Services Manager on using beard nets on 7/10/15.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br>All residents are considered to have a potential to be affected by the deficient practice. |  |



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| F 371 | <p>Continued From page 39</p> <p>storage area; and, failed to ensure three (3) of three (3) facial beards were restrained when preparing food on the tray line.</p> <p>Observations on 06/02/15 and 06/03/15 revealed the dry food storage room had food, debris and mice droppings on the floor (as identified by the Pest Control Technician).</p> <p>Review of the Pest Technician Service Report, dated 01/06/15, revealed the Pest Technician identified mice in the kitchen and he placed four (4) RTU (container to deliver bait to kill mice) baits down and five (5) glueboard traps down in the kitchen area for mice.</p> <p>Although the Pest Control had been in the facility monthly after 01/06/15, the Pest Technician stated this was one of the worst facilities as it related to pests, insects, rodents. Review of pest control records dated 02/03/15, 03/03/15, 04/08/15 and 05/05/15 revealed mice or other pests continued to be identified in the kitchen. Resident interview revealed evidence of mice chewing on bags of chips that were served on the meal tray.</p> <p>The facility's failure to have an effective system in place to ensure the facility kitchen was free of pest has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 06/04/15 and determined to exist on 01/06/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 06/11/15 which alleged removal of the Immediate Jeopardy on 06/10/15. The State Survey Agency verified Immediate Jeopardy was removed on 06/10/15, as alleged</p> | F 371 | <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur</p> <p>On 6/5/15 an extensive tour / inspection of the exterior and interior of the center was completed by the Administrator, Maintenance Director, Pest Control Service Technician and Pest Control Manager to determine if there were any signs of active pest issues. None were found. There were potential entry points noted where pests may have had the opportunity to enter the building where sealing around conduits, pipes and door sweeps had to be repaired or replaced. All issues noted during these extensive rounds were addressed and repaired by 6/10/15 by the Maintenance Director.</p> <p>The cleaning schedule in the dietary department was revised by the Dietary manager and has a designated position responsible for cleaning the dry storage area. The dry storage area is checked daily by the Dietary Services Manager. Dietary staff has been in serviced by the Dietary Services Manager on 6/11/15 on the cleaning schedule, reporting observations of pests, removing delivered supplies from the original boxes and storing in plastic containers.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance the Dietary Services Manager will inspect the Dry Storage area each day worked to assure area is clean and there is no evidence of pests. Any identified concerns will be addressed immediately.</p> |  |
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| F 371  | <p>Continued From page 40</p> <p>prior to exit on 06/18/15. The Scope and Severity was lowered to a "D" while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>1. Review of the Department Goals Policy, effective 08/01/12, revealed acceptable standards of sanitation would be maintained during all stages of food delivery, storage, preparation and service.</p> <p>Review of the facility's policy, Pest Control, dated 09/01/14, revealed the facility was to maintain an effective pest control program. In addition, an on-going pest control program was to be maintained to ensure the building was kept free of insects and rodents with assistance by maintenance services, as necessary.</p> <p>Review of the pest control contract, with CarePro Solutions, dated 02/03/14, revealed the company would provide services as needed to effectively control cockroaches, ants, rodents, or other insect infestations. Further review of the pest control contract revealed the company's treatment process would depend on feedback from the Pest Sightings Postings (documented on Pest Sighting Logs kept at the nurses' stations) or from a primary contact person.</p> <p>Review of the Cleaning Schedule, for 06/01/15, revealed the dry storage was not listed as an area to be cleaned daily.</p> <p>Review of the Centers' for Disease Control and</p> | F 371  | <p>The Administrator will make twice weekly rounds in the dietary department to review compliance with sanitation standards. The Maintenance Director will complete weekly exterior rounds continuing to monitor for potential entry points and will implement immediate interventions to prevent entry.</p> <p>The results of the weekly round audits completed by the Maintenance Director and the twice weekly Administrator reviews will be reviewed during the center's monthly QAPI meeting attended by: Administrator, Medical Director, DNS and two or more of the following: ADNS, MDS Nurse, Dietary, Social Services, Activities, Maintenance, Housekeeping or Specialized Rehab Therapy for further review and any additional interventions to maintain continued compliance. The results of the Dietary Services Managers audit of the dry storage area, the administrators twice weekly rounds in the dietary department and the results of the Maintenance Directors weekly round audits will be a standard agenda item for the center's monthly QAPI meeting.</p> | 7-22-15              |  |

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| F 371  | <p>Continued From page 41</p> <p>Prevention Integrated Pest Management: Conducting Urban Rodent Surveys, dated 2006, revealed a premise was considered infested as long as any active rodent signs existed. Rats and mice could contaminate food, damage structures, and carry diseases that threatened the health and quality of life, and they could cause injury (potential for bites) and death. In addition, whenever rodents find suitable food, water and harborage they become established and reproduce rapidly in premises with poor environmental quality.</p> <p>Review of the Pest Technician Service Report, dated 01/06/15, revealed the Pest Technician placed four (4) RTU (container to deliver bait to kill mice) baits down and five (5) glueboard traps down in the kitchen area for mice.</p> <p>Review of the Pest Technician Service Report, dated 02/03/15, revealed the Pest Technician placed two (2) Confrac Bait Blox and two (2) glueboard traps down in the kitchen area for mice.</p> <p>Review of the Pest Technician Service Report, dated 03/03/15, revealed the Pest Technician placed four (4) Confrac Bait Blox and eleven (11) glueboard traps in the kitchen area for mice.</p> <p>Review of the Pest Technician Service Report, dated 04/08/15, revealed the Pest Technician placed one (1) Confrac Bait Blox and five (5) glueboard traps in the kitchen area for mice.</p> | F 371  |   |                      |  |

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| F 371  | <p>Continued From page 42</p> <p>Review of the Pest Technician Service Report, dated 05/05/15, revealed the Pest Technician placed two (2) Confrac Bait Blox and three (3) glueboard traps in the kitchen area for mice.</p> <p>Observation of the dry storage area in the kitchen during initial tour, on 06/02/15 at 8:25 AM, revealed debris and black and white pellets on the floor in the corner of the dry storage area which appeared to be small black mice droppings.</p> <p>Observation of the dry storage area in the kitchen and interview with the Pest Technician, on 06/03/15 at 2:55 PM, revealed the black pellets on the floor were mice droppings. The Technician stated he could not tell how old the droppings were; however, he had placed a mouse trap in the dry storage area about two (2) months ago. The Technician stated the mouse trap was working because he observed additional blue mouse droppings on the dry storage floor. The Technician stated that he did not see any holes in the kitchen, but the mice could come in from additional sources. Further interview with the Technician revealed the mice could bite through anything except metal.</p> <p>Interview with Dietary Aid #1, on 06/04/15 at 4:25 PM, revealed he had cleaned the dry storage area before and saw a mouse on Sunday or Monday morning before the survey started. He stated he had swept up rice in the dry storage room.</p> <p>Interview with Cook #1, on 06/04/15 at 4:04 PM, revealed there was no one responsible to clean the dry storage area at this time. She stated there</p> | F 371  |   |                      |  |

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| F 371  | <p>Continued From page 43</p> <p>was a dietary aid who had been gone for three (3) weeks to a month who would complete tasks such as stocking food items, cleaning the refrigerators, stock room and dry storage area. Cook #1 stated the dietary staff had been working short. After reviewing the cleaning schedule, Cook #1 stated the schedule needed to be more detailed to reflect the cleaning of the dry storage area. She stated she wanted to prevent mice from coming into the kitchen because they were "nasty" and no one wanted to "eat mice poop". Cook #1 stated mice were dirty and she was scared of them.</p> <p>Interview with Cook #3, on 06/04/15 at 3:55 PM, revealed the person who was responsible to wash the dishes was responsible for cleaning the dry storage area. Cook #3 stated the dry storage area was a dirty area and she had seen mice as late as "yesterday" (06/03/15). She stated she had seen the mice mess with the rice in the dry storage area. Cook #3 stated she did not want rodents in the kitchen area because they could cause diseases.</p> <p>Interview with Dietary Aid #1, on 06/04/15 at 4:25 PM, revealed he had cleaned the dry storage area before and saw a mouse on Sunday 05/31/15 or Monday 06/01/15.</p> <p>Interview with the Dietary Manager, on 06/04/15 at 4:40 PM, revealed he had started noticing the mice back in December of 2014 and told the Administrator, Maintenance and the Pest Technician. The Dietary Manager stated there had been problems with mice about two (2) months ago getting into the bread supply. He further stated he was not aware the mice were getting in the dry storage rice supply. The Dietary</p> | F 371  |   |                      |  |

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| F 371  | <p>Continued From page 44</p> <p>Manager indicated he did not know what mouse droppings looked like so he did not know the mice were in the dry storage area. He stated he was not monitoring the Dry Storage area to ensure it was being cleaned by staff nor was the Dry Storage area on the cleaning schedule to be cleaned. The Dietary Manager stated he did not want mice in the kitchen because they carry diseases and could make the residents sick. The Dietary Manager stated he thought the mice were gone as of April 2015. However, interview with Dietary Aide #1 and Cook #3 on 06/04/15 revealed they had recently seen mice. Further interview with the Dietary Manger revealed "four (4) months was not a long time to have to deal with mice".</p> <p>Further interview with the Pest Technician, on 06/03/15 at 2:55 PM, revealed he had spoken to the Administrator in December of 2014 about the problem with rodents. The Pest Technician stated he informed the Administrator about the housekeeping and the uncleanliness of the facility and the impact that would have on getting rid of the pests. The Pest Technician stated this was one of the worst facilities as it related to pests, insects, rodents.</p> <p>2. Review of the Safety and Sanitation Policy, effective 08/01/12, revealed all dietary services personnel would wear hair nets or caps, or utilize appropriate hair restraint as designated by state law.</p> <p>Observation during the initial tour of the kitchen, during the breakfast meal service, on 06/02/15 at 8:20 AM, revealed Cook #2 and two (2) Dietary Aids were preparing breakfast trays, all three (3) workers were observed to have facial beards that</p> | F 371  |   |  |

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| F 371  | <p>Continued From page 45 were not restrained.</p> <p>Observation of the lunch meal, on 06/05/15 at 11:25 AM, revealed Cook #2 serving lunch meals from the tray line with a facial beard with no restraint.</p> <p>Interview with Dietary Aid #1, on 06/04/15 at 4:25 PM, revealed he was taught to wear hair restraints to prevent loose hair from falling in drinks and food.</p> <p>Interview with Cook #3, on 06/04/15 at 3:55 PM, revealed men were supposed to wear beard restraints to keep hair from getting into food. Cook #3 stated there were enough of the beard restraints and she had to ask the male dietary staff to wear them.</p> <p>Interview with the Dietary Manager, on 06/04/15 at 4:40 PM, revealed he educated the dietary staff to wear beard restraints. The Dietary Manager stated the staff wore the beard restraint just in case loose hair was to fall in the food.</p> <p>The State Survey Agency (SSA) verified the removal of Immediate Jeopardy on 06/10/15 prior to exit as follows:</p> <p>1. Observation of the exterior of the facility, on 06/17/15 at 4:00 PM, with the Maintenance Director and the Administrator revealed potential rodent entry points had been repaired as outlined on the document, Summary of Building Inspection Conducted 06/05/15. Observation of the interior of the facility, on 06/17/15 at 4:30 PM, revealed no active signs of pests/rodents.</p> <p>Review of the Summary of Building Inspection</p> | F 371  |   |                      |  |

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| F 371 | <p>Continued From page 46</p> <p>Conducted 06/05/15, revealed an inspection was conducted of the interior and exterior of the facility for the purpose of determining if there were any active signs of pest issues. Review of the document revealed a number of potential rodent entry points were located on the exterior of the building and the document listed those entry points and how those were addressed. The document further revealed the inspection was completed on 06/05/15 and repairs were completed on 06/07/15.</p> <p>Interview with the Administrator, on 06/17/15 at 3:00 PM, revealed he participated in the inspection of the interior and exterior of the facility on 06/05/15 at 4:00 PM. Interview with the Maintenance Supervisor, on 06/17/15 at 4:49 PM, revealed he participated in the inspection of the interior and exterior of the facility on 06/05/15 at 4:00 PM. Interview with the Pest Control Service Technician, on 06/17/15 at 5:15 PM, revealed he participated in the inspection of the interior and exterior of the facility on 06/05/15 at 4:00 PM. Interview with the Pest Control Service Manager, on 06/17/15 at 4:00 PM, revealed he participated in the inspection of the interior and exterior of the facility on 06/05/15 at 4:00 PM.</p> <p>Review of an Interior Rounds Checklist form and an Exterior Rounds Checklist form, each dated 06/05/15, revealed they had been completed and signed by the Maintenance Department Director and the Administrator.</p> <p>Observation of the exterior of the building, on 06/17/15 at 4:00 PM, revealed new door sweeps had been installed on the loading dock doors, holes outside the break room had been filled with concrete and two old plumbing lines had been</p> | F 371 |  |  |
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| F 371  | <p>Continued From page 47 filled with pipe.</p> <p>Observation of the interior of the building, on 06/17/15 at 4:30 PM, revealed a hole had been filled in the dishroom, the 1C elevator room had a hole filled, the outside break room had a hole filled, a hole was filled in room #126, door sweeps were installed on two (2) utility room doors, and a new door sweep was installed at the employee entrance as alleged.</p> <p>Interview with the Maintenance Supervisor, on 06/17/15 at 4:49 PM, revealed he had completed the weekly rounds monitoring forms on 06/05/15 and will continue the weekly monitoring rounds to include visual checks of interior mechanical, utility, supply rooms for potential issues and implementing interventions. He stated the results of the weekly rounds would be reviewed during the monthly Quality Assurance Performance Improvement (QAPI) meeting.</p> <p>2. Review of documents titled Pest Control Questionnaire (undated) and resident census lists indicating residents' answers to the questions with a signature (when possible) revealed all interviewable residents were asked about concerns with pests. Review of Departmental Nursing Notes revealed all residents were either assessed or interviewed regarding any signs or symptoms of health problems associated with pests or uncleanliness in the facility.</p> <p>Interview with Resident #4, on 06/18/15 at 8:00 AM, Resident #5, on 06/18/15 at 8:20 AM, Resident #7, on 06/18/15 at 8:30 AM, Resident #10, on 06/18/15 at 8:40 AM, Resident #15, on 06/18/15 at 9:00 AM, Resident #16, on 06/18/15 at 9:20 AM, Resident #18, on 06/18/15 at 9:30</p> | F 371  |   |  |

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| F 371  | <p>Continued From page 48</p> <p>AM, Resident #20, on 06/18/15 at 9:30 AM, Resident #27, on 06/18/15 at 10:00 AM, Resident #30, Resident #31, on 06/18/15 at 10:10 AM, Resident #32 on 06/18/15 at 10:25 AM, Unsampld Resident B, on 06/18/15 at 11:00 AM, Unsampld Resident G, on 06/18/15 at 11:12 AM, Unsampld Resident J, 06/18/15 at 11:30 AM, and Unsampld Resident M, on 06/18/15 at 11:45 AM, revealed they had all been interviewed by the Director of Nursing (DON) or one of the two (2) Assistant Directors of Nursing (ADON) regarding pests or possible adverse health consequences from pests.</p> <p>Interview with the DON, on 06/18/15 at 10:48 AM, revealed she had participated in resident interviews and assessments regarding pests or possible adverse health consequences from pests. Interview with the Assistant ADON #1, on 06/18/15 at 9:41 AM, revealed she participated in resident interviews and assessments regarding pests or possible adverse health consequences from pests. Interview with ADON #2, on 06/18/15 at 9:38 AM, revealed she participated in resident interviews and assessments regarding pests or possible adverse health consequences from pests.</p> <p>3. Review of the In-service Sign-in Sheet, dated 06/05/15, revealed the topic of the in-service was pest control logs-utilization, center leadership notification and notifying the individual department leader, review and follow up of the pest control logs and the education of team members and the review of concerns (staff) may have regarding pest control. Team member/staff education to be completed for all staff members.</p> <p>Review of the document further revealed it was</p> | F 371  |   |                      |  |

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| F 371  | <p>Continued From page 49</p> <p>presented by the Director of Clinical Operations and was signed by the Administrator, the Clinical Educator, the DON and the ADON #1 and #2.</p> <p>Interview with the Director of Clinical Operations, on 06/17/15 at 3:20 PM, revealed he had trained the facility leadership to include the Administrator, the Clinical Educator, the DON and the ADON #1 and #2.</p> <p>Interview with the Administrator, on 06/17/15 at 3:00 PM, the Clinical Educator on 06/18/15 at 9:46 AM, the DON, on 06/18/15 at 10:48 AM and the ADON #1, on 06/18/15 at 9:41 AM, and ADON #2 on 06/18/15 at 9:38 AM revealed they had attended the in-service given by Corporation Representative, Director of Clinical Operations.</p> <p>Review of staff In-service Sign-in sheets with comparison to the employee roster dated 06/04/15 through 06/09/15 revealed one hundred fifty-one (151) employees were educated with twenty (20) employees educated by telephone. One employee remained on Family Medical Leave Act (FMLA) and would receive the education before returning to work. The education consisted of reviewing the employee's responsibility to provide written communication when a pest issue was identified.</p> <p>Interview with Licensed Practical Nurse (LPN) #14, on 06/18/15 at 2:00 PM, revealed she had received an in-service on 06/06/15 about putting any pest sightings in the pest activity log.</p> <p>Interview with LPN #7, on 06/18/15 at 2:15 PM, revealed she had been in-serviced about pest control on 06/06/15.</p> | F 371  |   |  |

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| F 371  | Continued From page 50<br><br>Interview with Certified Nursing Assistant (CNA) #3, on 06/18/15 at 2:08 PM, revealed she received an in-service on 06/06/15 about putting any pest sighting in the activity log and to notify her supervisor.<br><br>Interview with a Receptionist, on 06/18/15 at 1:52 PM, revealed she had received an in-service about reporting any pest sighting on 06/05/15.<br><br>Interview with the Social Services Director, on 06/18/15 at 9:59 AM, revealed she had been in-serviced on 06/05/15 about the pest control reporting.<br><br>Interview with CNA #7, on 06/18/15 at 2:05 PM, revealed she had been inserviced on 06/08/15 about how to report pest sightings and to whom to report.<br><br>Interview with Cook #3, on 06/18/15 at 2:17 PM, revealed he had been inserviced on 06/07/15 about how and to whom to report pest sightings.<br><br>Interview with CNA #8, on 06/18/15 at 2:20 PM, revealed he had been inserviced on pest sightings in the facility on 06/08/15 regarding responsibility to log any sightings in the pest activity log and report to his supervisor.<br><br>Interview with Housekeeper #3, on 06/18/15 at 2:25 PM, revealed he had been inserviced on 06/07/15 on pest sightings, where to document those sightings and to notify his supervisor of any sightings.<br><br>Interview with the Activities Director, on 06/18/15 at 2:26 PM, revealed she had been inserviced on | F 371  |   |                      |  |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |  |
| F 371  | <p>Continued From page 51</p> <p>06/07/15 on reporting of any pest sightings on the pest activity log and to notify her supervisor of any sightings.</p> <p>Interview with LPN #11, on 06/18/15 at 2:45 PM, revealed she had been in-serviced on 06/08/15 regarding reporting any pest sightings and notification of her supervisor if she did.</p> <p>Post survey interview with the DON, on 07/02/15 at 10:39 AM, revealed the staff who was telephonically inserviced on 06/05/15 to 06/08/15 were retrained upon return to work. The staff person on FMLA (CNA #10) was re-inserviced upon return to work.</p> <p>Post survey interviews, on 07/02/15, with CNA #10 at 11:00 AM, CNA #11 at 11:09 AM, CNA #12 at 11:25 AM, CNA #13 at 11:45 AM, and LPN #15 at 11:37 AM, revealed they had all received education over the telephone and could specify the information provided to them. They further stated the Director of Nursing discussed the education with them after they returned to work for their scheduled shifts.</p> <p>4. Review of the Summary of Pest Control Service Agreement Review revealed the Administrator met with the Maintenance Director, the Pest Control Service Technician, the Pest Control Services Manager and the President of the Pest Services to review the pest service agreement and no changes were made on 06/05/15.</p> <p>Interview with the Administrator, on 06/17/15 at 5:07 PM, revealed he met with the Maintenance Director, the Pest Control Service Technician, the Pest Control Services Manager and the President</p> | F 371  |   |                      |  |

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:<br><br><b>185039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>06/18/2015</b> |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HIGHLANDS HEALTH AND REHABILITATION CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1705 STEVENS AVENUE<br/>LOUISVILLE, KY 40205</b>                    |                      |   |
| (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 371   | <p>Continued From page 52 of the Pest Services to review the pest service agreement and no changes were made on 06/05/15.</p> <p>Interview with the Maintenance Director, on 06/17/15 at 4:49 PM, revealed he met with the Administrator, the Pest Control Service Technician, the Pest Control Services Manager and the President of the Pest Services to review the pest service agreement and no changes were made on 06/05/15.</p> <p>Interview with the Pest Control Service Technician, on 06/17/15 at 5:15 PM, revealed he met with the Administrator, the Maintenance Director, the Pest Control Services Manager and the President of the Pest Services to review the pest service agreement and no changes were made on 06/05/15.</p> <p>Interview with the Pest Control Services Manager, on 06/17/15 at 4:00 PM; and, the President of the Pest Control Services, on 06/18/15 at 2:38 PM, revealed they met with the Administrator, the Maintenance Director, and the Pest Control Service Technician to review the pest service agreement and no changes were made on 06/05/15.</p> <p>5. Review of the document, entitled Quality Assurance Review revealed a Quality Assurance Review meeting was held on 06/08/15 for the purpose of discussing the Immediate Jeopardy deficiencies that had been identified in the areas of F469, F490 and F520.</p> <p>Review of the Quality Assurance Review Committee sign-in sheet, dated 06/08/15, revealed it was signed by the Administer, the</p> | F 371   |   |                      |   |

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|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>HIGHLANDS HEALTH AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1705 STEVENS AVENUE<br>LOUISVILLE, KY 40205                            |                      |  |
| (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 371  | Continued From page 53<br>DON, the Social Services Director, the Maintenance Director, Environmental Services #1, Environmental Services #2, Regional Director of Housekeeping, and the Medical Director.<br><br>Interview with the Administrator, on 06/17/15 at 3:00 PM, revealed he reviewed the weekly rounds monitoring forms completed by the Maintenance Director on 06/05/15, he will continue to monitor them and he will take them to the monthly Quality Assurance Review Committee meeting for review.<br><br>Interview with the Administrator, on 06/18/15 at 5:07 PM; the DON on 06/18/15 at 10:48 AM; the Social Services Director, on 06/18/15 at 10:00 AM; the Maintenance Director, on 06/17/15 at 4:49 PM; Environmental Services #1, on 06/18/15 at 11:00 AM; Environmental Services #2, on 06/18/15 at 11:20 AM; Regional Director of Housekeeping, on 06/18/15 at 11:40 AM; and, the Medical Director, on 06/18/15 at 11:50 AM revealed they had all attended the Quality Assurance Review Committee meeting held on 06/08/15 to discuss the Immediate Jeopardy issues. During the interview with the Administrator, on 06/18/15 at 5:07 PM, he stated he would review the overview assessment of the pest control log books to help identify any trends or patterns. If any trends/patterns were identified additional interventions will be included in the Quality Assurance Review minutes with follow up by members as needed. In addition, the pest control services monthly reports would be reviewed in the monthly Quality Assurance Review Committee meeting. | F 371  |   |                      |  |
| F 469<br>SS=K  | 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM   | F 469  |   |                      |  |

