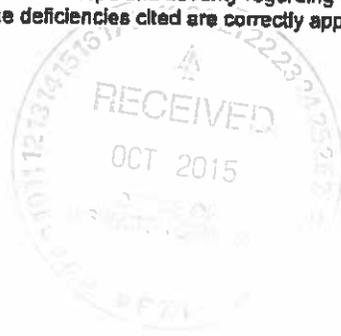


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/25/2015
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW			STREET ADDRESS, CITY, STATE, ZIP CODE 108 HOMEWOOD BLVD. GLASGOW, KY 42141	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating Complaint #KY23647 was conducted on 08/07/15 through 08/25/15. Complaint #KY23647 was substantiated with deficiencies cited at the highest Scope and Severity of a "G". The facility assessed Resident #2 as needing the assistance of two (2) staff for bathing and bed mobility; however, the facility failed to revise the care to address the resident's need of two (2) staff for a bed bath. On 06/21/15, Certified Nurse Aide (CNAs) #1 provided a bed bath without the assistance of another staff member to ensure there was adequate supervision and assistance during the bed bath. When CNA #1 turned to obtain a washcloth, the resident turned over and fell out of the bed. Resident #2 sustained bilateral nasal bone fractures, a bilateral subarachnoid hemorrhage, and a small subdural hematoma extending along the right temporal frontal region.	F 000	This plan of correction is submitted as required under state and federal law. The submission of this plan does not constitute an admission on the part of NHC Glasgow as to the accuracy of the surveyor's findings nor the conclusion drawn, that a deficiency exists or that the scope and severity regarding any of the deficiencies cited are correctly applied.	10/09/15
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the	F 164	Unsampled Resident I was not identified on Residents identifying list, however all records have remained secure/private since 8/26/15. Residents A, B, D and E have had their privacy maintained during med pass since 8/26/15. All residents have the potential to be affected by these practices. Observations of all four (4) nurses' stations at various times of days and various days of the week, have not revealed any patient record left in view or left unattended since 9/11/15. Weekly Observations continue to be completed by staff including administrator, DON, HIM, unit managers, social services, and dietary.	10/09/15



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

TITLE

(X6) DATE

Denise Billingsley Administrator 10/20/15

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 164	<p>Continued From page 1</p> <p>release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to ensure information contained in residents records remained confidential for five (5) of nine (9) unsampled residents (Resident A, B, D, E, and I). The facility failed to ensure staff did not leave Unsampled Resident I's chart unattended on top of the counter at Station #2 and failed to ensure Intelligent Medication Administration Records (IMARs) for Unsampled Residents A, B, D, and E, were closed/minimized on the computer when the medication cart was left unattended.</p> <p>The findings include:</p> <p>Review of the facility's, Security of Protected Health Information (PHI) During Day To Day Operations Policy, last revised 09/01/13, revealed all chart binders should not be left lying open on the desk when not in use and the Medication and</p>	F 164	<p>Weekly Observations of medication administration monitor screens at various times of day and various days of the week, on all nine (9) medication carts, to ensure staff have had the monitor screens minimized to maintain privacy are being conducted..</p> <p>Weekly Observations began 9/2/15 and continue. They are conducted by staff including: administrator, DON, HIM, unit managers, social services, and dietary.</p> <p>The policy to maintain privacy of records by not leaving chart binders open while unattended will be followed.</p> <p>The policy to minimize the Medication Administration Record (MAR) monitor screen on the medication cart will be followed.</p> <p>All partners accessing resident records were in-serviced on "Security of Protected Health Information" policy beginning 9/11/15 and will be complete by 10/09/15. The Health Information Manager and the Staff Development Coordinator (LPN) have conducted these in-services.</p> <p>All licensed nurses have been in-serviced on minimizing the iMAR (Medication Administration Record) screens beginning 8/31/15 through 09/21/15 by the Staff Development Coordinator (LPN)</p> <p>iMAR training/re-training for licensed nurses is scheduled for 9/24/15 and will also include importance of minimizing screen. The Consultant Pharmacists(s) will present.</p>		

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F 164	<p>Continued From page 2</p> <p>Treatment Administration Record (MAR and TAR) books should not be left open on the medication cart.</p> <p>1. Observation, on 08/10/15 at 11:31 AM, revealed Unsampld Resident I's record was placed on the top counter of Station #2 with no staff in view.</p> <p>Interview, on 08/10/15 at 11:34 AM with Unit Manager #2, revealed the residents' information should not have been on the counter to see.</p> <p>2. Observation during a medication pass at Station #4, on 08/20/15 at 11:55 AM, revealed Licensd Practical Nurse (LPN) #19 administered medication to two (2) residents (Unsampld Resident A and B) and failed to close/minimize the IMAR for each resident on the computer prior to leaving the medication cart unattended.</p> <p>3. Observation of a medication pass at Station #3, on 08/19/15 at 9:40 AM, revealed LPN #3 administered medications to two (2) residents (Unsampld Resident D and E). LPN #3 failed to close/minimize the IMAR for each resident on the computer prior to leaving the medication cart unattended.</p> <p>Interview with LPN #3, at the time of the observation, revealed she should have closed the screen prior to leaving the cart to ensure residents' information could not be seen by others.</p> <p>Interview with Unit Manager #3, on 08/20/15 at 12:30 PM, and Unit Manager #4, on 08/21/15 at 12:00 PM, revealed the IMAR screen should be minimized when the medication cart was left</p>	F 164	<p>Quality Assurance monitoring of resident record and MAR privacy began 9/2/15 and continues. These monitors will continue until the Quality Assurance Committee affirms compliance.</p> <p>The Staff Development Coordinator (LPN) will coordinate these monitors and report to QA Committee, monthly. QA Committee members include:</p> <p>Medical Director Attending Physicians Administrator DON HIM Director Unit Managers ADON Social Services Director Dietary Director Rehab Director</p> <p>QA/QI Meeting is typically the 4th Tuesday of each month.</p>		

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F 164	Continued From page 3 unattended so resident information would not be on screen for others to see.	F 164			
F 279 SS=D	Interview with the Director of Nursing (DON), on 08/25/15 at 5:30 PM, revealed staff should minimize the screen prior to leaving the medication cart unattended, as per policy. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility policy, and review of Hospital Discharge Orders, it was determined the facility failed to develop a comprehensive care plan for one (1) of	F 279	Resident #4 was discharged from facility on 06/03/15. All residents on "blood thinners" have the potential to be affected by this practice. All residents on Coumadin had their care plans audited to assure care plan problems regarding use of Coumadin, with appropriate interventions were present. Those residents without a Coumadin care plan were put into place. This was completed by 08/26/15. This order was completed by RN consultant. Residents on aspirin had their care plans reviewed on 9/15/15 to assure care plan problems and appropriate interventions were in place with regards to use of aspirin. Those residents without care plan problems had them added. The RN unit manager(s) completed audit.	10/09/15	

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F 279	<p>Continued From page 4</p> <p>fourteen (14) sampled residents (Resident #4) that described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>The facility admitted Resident #4 on 05/18/15 on blood thinners (Coumadin, Brilinta, and Aspirin). The facility developed a Comprehensive Care Plan related to the resident's history of a Valve Replacement and receiving Coumadin. However, the facility did not address that the resident was also on Brilinta and Aspirin (also blood thinners) which increased the resident's risk for bleeding.</p> <p>The facility also failed to develop interventions for staff to conduct ongoing assessments due to the resident's high risk for bleeding; and interventions to monitor the International Normalization Ratio (INR) with a desired range of 2.5-3.5, per Physician's Order.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Development Policy, last revised 07/03/08, and the facility's Medical Record Manual page III.K.17, last revised 06/10/11, revealed the Interim Care Plan should address the immediate needs of the resident (the issues that caused admission, falls risk, pressure ulcer risk, adaptive equipment, feeding and hydration needs, and any other known facts from transfer information or from immediate assessment and resident complaints.) The Care Plan should be completed in an interdisciplinary conference within seven (7) days of completion of the Minimum Data Set (MDS). Nursing staff as close to the resident care as possible, Social Worker, Recreation, Dietary, and other disciplines as appropriate for the particular resident are</p>	F 279	<p>Residents on blood thinning medications other than Coumadin or aspirin had their care plans reviewed on 9/15/15 to assure that care plan problems and interventions were present. Those patients without care plan problems had care plan problems added. RN unit manager(s) completed audit.</p> <p>All newly admitted or re-admitted residents since 8/26/15 had their records/care plans reviewed to assure care plan problems for any blood thinning medication use with interventions were present. RN consultant completed audit. This audit is ongoing with all newly admitted and re-admitted residents. The Unit Managers and DON or designee complete these audits.</p> <p>The "Care Plan Development" policy regarding developing, revising and updating care plans will be followed.</p> <p>All new physician orders are printed by each Unit Manager daily and care plan revised as needed.</p> <p>All licensed nurses will be in-serviced on care plan policy during monthly licensed nurse meetings on 9/21/15. Meeting will be conducted by the DON.</p> <p>Coumadin administration in-services were held for licensed nurses on 9/10/15. These were presented by the consultant pharmacist. Those licensed nurses not in attendance will receive 1:1 education from Staff Development Coordinator (LPN) by 09/21/15.</p>	

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F 279	<p>Continued From page 5</p> <p>responsible for developing the resident's care plan. The problem should be determined by how the condition affects the resident's well-being (not partners ability to do their work). The care plan goals may be short-term, long-term, or intermediate goals that should lead to a reasonable attainable objective. The timeframes should be set according to the needs of each individual. Care plan approaches should be specific, individualized steps staff and the residents will take together to assist the resident to achieve the goal. Resident problems should be identified with time limited goals and specific approaches to reach each goal. The care plan should be individualized to meet the needs of the resident.</p> <p>Record review revealed the facility admitted Resident #4 on 05/18/15 with diagnoses which included Congestive Heart Failure, Heart Valve Replacement by Mechanical Device, Paroxysmal Atrial Flutter and Long Term (Current) Use of Anticoagulant (blood thinner).</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/25/15, revealed the facility assessed Resident #4's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) indicating the resident was not interviewable. In addition, the facility assessed Resident #4 as having a diagnosis of Long Term (Current) Use of Anticoagulant (blood thinner) and receiving an anticoagulant seven (7) days during the last seven (7) days.</p> <p>Review of the Discharge Orders from the hospital, dated 05/18/15, revealed an order for Coumadin 7.5 milligrams (mg) by mouth daily,</p>	F 279	<p>Quality Assurance monitoring began 08/30/15 to assess the presence of and accuracy of blood thinning medications care plan problems and interventions and will continue until Quality Assurance Committee determines compliance has been maintained. Each RN or LPN unit manager monitored weekly. Monitors were update on 09/11/15 to include other blood thinning medications and aspirin.</p> <p>The DON will compile data and report to QA Committee monthly until the committee determines compliance has been maintained.</p>	

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F 279	<p>Continued From page 6</p> <p>Brilinta 90 mg by mouth twice daily. Aspirin Enteric Coated (EC) 81 mg by mouth daily and to obtain an INR on 05/20/15 with an INR goal of 2.5-3.5 (diagnoses of mech mitral valve). Review of the Admission Orders reconciled by the facility's Physician, dated 05/18/15, revealed the same orders.</p> <p>Review of the Comprehensive Care Plan for History of Valve Reptacement which included Coumadin Therapy, dated 05/18/15, revealed the care plan did not identify that the resident was at an increased risk for bleeding due to receiving Coumadin, Brilinta and Aspirin. The Care Plan also failed to address the need for ongoing assessments to identify signs and symptoms of bleeding such as bruising, nose bleed, bloody stools, etc. In addition, there were no interventions to address the monitoring of the INR level to identify if the resident's INR had reached the goal of 2.5-3.5, per Physician's Order.</p> <p>Interview with Unit Manager #3, on 08/20/15 at 12:30 PM, revealed the Admission Nurse implements the Interim Care Plan and the MDS Nurse puts the Comprehensive Care Plans in the computer.</p> <p>Interview with MDS Staff #2, on 08/24/15 at 4:33 PM, revealed the MDS Assessment was used as a guide to develop and revise the Comprehensive Care Plan. MDS Staff #2 stated the floor nurse comes to the care plan meeting and MDS staff read off the interventions and the floor nurse reveals if accurate or not. She was unable to provide an explanation as to why a care plan was not developed to address the resident's anticoagulants (blood thinners).</p>	F 279			

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F 279	Continued From page 7 Interview with the Director of Nursing (DON), on 08/25/15 at 5:30 PM, revealed the residents' care plans should be individualized to match the resident's needs and diagnoses.	F 279			
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review and review of the Hospital History of Present Illness and Acute Care Hospital (ACH) Record, it was determined the facility failed to revise a care plan for one (1) of fourteen (14) sampled residents (Resident #2) that addressed	F 280	Resident #2 had their care plan reviewed and revised on 08/26/15 by RN unit manager. Although Resident #2 was coded as needing two (2) assist on the MDS dated 4/23/15, the resident does not always require assist of two (2) for bed mobility and bathing, however facility will provide 2 assistants for bed bathing to ensure safety. As per the CMS RAI MDS 3.0 manual, Section G, page G3 Definitions "ADL support provided measures the most support provided by staff over the last seven (7) days, even if that level of support only occurred once. Also, per CMS RAI MDS 3.0 Manual Section G, page G4, coding instructions for each ADL activity bullet points #6 and #7 state: • #6 - Resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the	10/09/15	

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F 280	<p>Continued From page 8</p> <p>the resident's assessed need of two (2) staff for bathing and bed mobility.</p> <p>Resident #2 was assessed by the facility as requiring the assistance of two (2) staff for bathing and bed mobility. However, the facility failed to revise the care plan to reflect the need for two (2) assist with bathing or bed mobility. On 06/21/15, Certified Nurse Aide (CNA) #1 was providing a bed bath to Resident #2 without the assistance of another staff. When she turned to obtain a washcloth, Resident #2 turned over and fell out of bed. Resident #2 sustained bilateral nasal bone fractures, a bilateral subarachnoid hemorrhage, and a subdural hematoma along the right temporal frontal region.</p> <p>The findings include:</p> <p>Review of the facility's Medical Record Manual, last revised 06/10/11, revealed resident problems should be identified — with time limited goals and specific approaches to reach each goal. The care plan should be individualized to meet the needs of the resident with the discipline responsible for each approach identified.</p> <p>Review of the facility's "Documentation Guidelines, Care Plan Development, last revised 07/03/08, revealed nursing staff as close to the resident care as possible. Social Worker, Recreation, Dietary, and other disciplines as appropriate for the particular resident were responsible for developing the resident's care plan. The problem should be determined by how does the condition affected the resident's well-being (not their partner's ability to do their work). The care plan goals may be short-term, long-term, or intermediate goals that should lead</p>	F 280	<p>person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.)</p> <p>#7 - The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common. Refer to the algorithm on page G-6 for assistance in determining the most appropriate self-performance code.</p> <p>Resident #2's care plan and CNA care card were updated 08/26/15 to reflect current support provided for ADL's by the RN unit manager.</p> <p>Resident #2 has not sustained any fall or injury since 06/02/15. The care plan problem addressing fall risk was also updated 08/26/15 by the RN unit manager.</p> <p>Resident #2's bed has been found in low position all times observed since 8/26/15. Random observations were completed by the RN unit manager.</p> <p>All residents have the potential to be affected by this practice.</p>	

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F 280	<p>Continued From page 9</p> <p>to a reasonable attainable objective. The timeframes should be set according to the needs of each individual. Care plan approaches should be specific, individualized steps staff and residents will take together to assist the resident to achieve the goal. Further review revealed the care plans should be updated as needed. In addition, new problems should be handled as they arise, and should be added to the current care plan even if the change in condition is not considered significant enough for a complete revision.</p> <p>Record review revealed the facility admitted Resident #2 on 08/30/08 with diagnoses which included Alzheimer's Disease, Arthritis, Late Effects of Cerebrovascular Disease, Vertebral Artery Syndrome, Insomnia, Depression with Anxiety, and Dementia.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment, dated 04/23/15, revealed the facility assessed Resident #2's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. In addition, the facility assessed the resident as requiring total assistance of two (2) for bathing and bed mobility. Bed mobility was defined as how the resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.</p> <p>Review of Resident #2's Comprehensive Care Plan for Activities of Daily Living (ADLs), dated 05/07/15, revealed interventions for staff assistance with bathing, dressing and grooming. However, the care plan did not specify the number of staff needed for bathing, dressing and grooming. In addition, review of Resident #2's</p>	F 280	<p>All residents that have fallen from 8/1/15 to present have had their care plan reviewed to determine if their care plan required updating reflective of their care support status. The CNA care cards were also reviewed to reflect the care plan interventions. The RN consultant performed these audits.</p> <p>The MDS Coordinators (RN) have reviewed the care plans and CNA care cards and revised as needed relative to the ADL assistance required and falls interventions for all residents. This was completed by 09/20/15</p> <p>The "Care Plan Development" policy regarding developing, revising and updating their care plan will be followed. Care plans will be reviewed and revised at least quarterly to reflect the patient's individualized needs. At the same time, the CNA care card will be updated.</p> <p>Care plans will be revised as needed reflective of new physician orders by the nurse obtaining order. Any change that affects the care provided by the CNA will result in the CNA care card being updated.</p> <p>Residents re-admitted to facility have had/ will have their records reviewed to assure care plans and CNA care cards reflect their current needs. This is done by the Unit Managers and the DON or designee.</p> <p>In-servicing on fall reduction was conducted on 9/10/15 and 9/11/15 by RN consultant and consultant therapist. During this in-service the importance of revising care plans, as well as CNA care cards was stressed.</p>	

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F 280	<p>Continued From page 10</p> <p>August 2015 CNA Care Plan revealed the resident required the assist of two (2) staff for turning and positioning in bed. The CNA care plan did not address how many staff was needed for a bed bath which would require turning and positioning the resident.</p> <p>Review of a Nursing Note, dated 06/21/15 at 10:30 AM, and review of a Post Fall Nursing Assessment and Post Fall Investigation, dated 06/22/15, revealed Registered Nurse (RN) # 8 was called to Resident #2's room by CNA #1. CNA #1 told the nurse that Resident #2 had fallen from the bed during his/her bed bath. Resident #2 was laying on the floor on his/her right side with his/her right side of face to the floor; there was blood on the floor coming from the resident's nose. The resident had a laceration to the right side of the forehead under his/her right eye and the nose was visibly disfigured. The resident rated his/her pain as four (4) out of ten (10).</p> <p>Review of Hospital History of Present Illness, dated 06/21/15, and Computerized Axial Tomography Scan (CT Scan) without contrast, of Resident #2's head, dated 06/21/15, revealed Resident #2 sustained bilateral nasal bone fractures, a small amount of bilateral subarachnoid hemorrhage, and a small subdural hematoma extending along the right temporal frontal region. Review of Acute Care Hospital (ACH) Record, dated 06/21/15, revealed Resident #2's final diagnoses was Right Subdural Hematoma, and Traumatic Subarachnoid Hemorrhage and the resident was discharged back to facility on 06/22/15 at 10:10 AM.</p> <p>Interview with Resident #2, on 08/12/15 at 10:30 AM, revealed he/she was being given a bed bath</p>	F 280	<p>Additional inservices are scheduled for 09-22-15 and 09-24-15. Any partner unable to attend will receive 1:1 training from Staff Development Coordinator (LPN) by 09/26/15.</p> <p>All licensed nurses will also (again) be in-serviced on care plans policy during monthly licensed nurse meetings held 9/22/15, conducted by the DON.</p> <p>CNA's will be in-serviced on updating, location and utilization of CNA care cards at monthly CNA in-services on 9/23/15, conducted by the DON.</p> <p>Quality Assurance monitoring to assure care plans and CNA care cards are updated post fall was initiated on 8/30/15. Each unit manager (RN or LPN) monitors for any residents with a fall.</p> <p>A second QA monitor to assure care plans and if applicable, CNA care cards are updated post any new physician order, was also begun on 8/30/15. Each unit manager (RN or LPN) monitors weekly.</p> <p>The data will be completed and the QA report will be completed by the DON and reported to the QA Committee monthly until committee determines compliance is maintained.</p>	

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F 280	<p>Continued From page 11</p> <p>by CNA #1 when he/she fell from the bed. The resident stated CNA #1 was standing on the left side of the bed. When the CNA turned him/her over, he/she went over the right side of the bed, and hurt his/her face so bad he/she had to go to an acute care hospital and stayed for a week.</p> <p>Interview with CNA #1, on 08/22/15 at 1:16 PM, revealed Resident #2 was two person (2) assist with activities of daily living but the resident was able to wash the upper part of his/her body. CNA #1 stated the day of Resident #2's fall she did not remember if she set him/her up for the bath or if she gave the whole bath. She stated while she was getting the wash cloth off the bedside table to rinse Resident #2 off, the resident started to roll to his/her back and she told him/her she was not done. Continued interview revealed the resident rolled back over and his/her head went up and over the 1/4 side rail, hit the nightstand, and hit his/her eye and nose on the floor and landed on the right side. CNA #1 stated the other CNA was giving Resident #2's roommate a bed bath and was not assisting her with the bed bath at the time.</p> <p>Interview with CNA #18, on 08/24/15 at 12:18 PM, revealed she was giving Resident #2's roommate a bed bath with the curtain around the bed and CNA #1 was giving Resident #2 a bed bath. CNA #18 stated CNA #1 had the bed at waist level (three to four {3-4} feet high), and she heard CNA #1 tell Resident #2 to hold on, she was getting a cloth to wash his/her back. CNA #18 stated after that she heard the resident fall.</p> <p>Interviews (Post Survey) on 09/04/15 with CNA #21 at 3:07 PM and CNA #27 at 3:08 PM, revealed CNAs looked at the CNA Care Plan to</p>	F 280			

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F 280	Continued From page 12 determine the amount of staff needed to provide care for each resident. She stated the CNA care plans were updated daily. Interview with MDS Staff #2, on 08/24/15 at 4:33 PM, revealed the MDS assessment was used as a guide to develop and revise the comprehensive care plan, and the CNA care plan was made from the Comprehensive Care Plan and they should match at all times. MDS Staff #2 stated the floor nurse attended the care plan meeting and MDS Staff #2 reads the interventions and the floor nurse verifies if they are accurate or not. MDS Staff #2 also stated there were several new nurses and there have been issues with the care plans not being updated until the meeting. Interview with the Director of Nursing (DON), on 08/25/15 at 6:00 PM, revealed the MDS staff and nurses developed and updated the care plan and it should be updated/ revised at any point that the Plan of Care changed for a resident. Interview with the Interim Administrator, on 08/25/15 at 5:40 PM, revealed she expected staff to follow facility guidelines, policies, and standards of practice related to the care and interventions provided to the residents.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282	Resident #1 had their care plan updated to reflect accurate assessment information for this resident. Resident #1's CNA care plan card was updated to match the care plan. This was completed on 08/26/15. Resident #1's need for assistance varies from time to time and day to day, however two assist will be provided for bed bathing activities to ensure safety.	10/09/15	

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F 282	<p>Continued From page 13</p> <p>by: Based on interview, record review and facility policy review it was determined the facility failed to provide services in accordance with each resident's written plan of care for one (1) of fourteen (14) sampled residents (Resident #1).</p> <p>Resident #1 was assessed and care planned for two (2) staff assistance for bathing; however, on 06/12/15, Certified Nurse Aide (CNA) #2 provided a bed bath to Resident #1 without the assistance of another staff as care planned. CNA #2 rolled the resident to his/her side and left the resident unattended to obtain a washcloth. Resident #1 fell from the bed and sustained an injury to the right knee that required the use of an ace bandage and then returned to normal activities.</p> <p>The findings include:</p> <p>Review of the facility's booklet titled Patient Rights, with revision date of 09/2014 revealed the patient's care is planned with a group of professionals holding the resident's well-being as their primary concern. A plan of care will be developed to address the resident's physical and psychosocial needs. The ultimate goal is to assist the resident to achieve and/or maintain the highest level of functioning possible within the limits set by their medical condition and wishes regarding the plan. A written plan of care is developed individually.</p> <p>Record review revealed the facility admitted Resident #1 on 07/10/13 with diagnoses which included Malaise and Fatigue, Osteoarthritis, Late Effects of Cerebrovascular Disease, Congestive Heart Failure, Neuropathy, and Debility. Review of the Quarterly Minimum Data Set (MDS)</p>	F 282	<p>Although Resident #1 was coded as needing two (2) assist on the MDS dated 4/7/15 MDS, the resident does not always require assist of two (2).</p> <p>As per the CMS RAI MDS 3.0 manual, Section G, page G3 Definitions "ADL support provided measures the most support provided by staff over the last seven (7) days, even if that level of support only occurred once. Also, per CMS RAI MDS 3.0 Manual Section G, page G4, coding instructions for each ADL activity bullet points #6 and #7 state:</p> <ul style="list-style-type: none"> #6 - "A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.)" 	

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F 282	<p>Continued From page 14</p> <p>Assessment, dated 04/07/15, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) for bed mobility and total assistance of two (2) with bathing.</p> <p>Review of the Comprehensive Care Plan for Activities of Daily Living (ADL), dated 04/15/15, revealed Resident #1 required total care with most ADLs, and to help the resident to bathe, groom, and dress the portions he/she was unable to do by himself/herself. However, the care plan did not specify the number of staff needed for a bed bath that would involve turning and repositioning the resident in bed. Review of the CNAs ADL Care Plan revealed the resident required two (2) persons to assist with care for bathing.</p> <p>Review of the Post Fall Assessment, dated 06/12/15 at 9:50 AM; review of the written interview of CNA #2 completed by the DON, dated 06/12/15; and, interview with Licensed Practical Nurse (LPN) #6, on 08/13/15 at 2:30 PM, revealed CNA #2 was giving Resident #1 a bed bath. The CNA turned the resident to his/her side, then the CNA turned to obtain a washcloth and the resident's legs slipped off the bed resulting in the resident falling out of the bed. Resident #1 was found up on his/her forearms and knees, with bruises to his/her bilateral knees. Skin tears were noted to the resident's bilateral hands and arms.</p> <p>Review of the Physician's Consultation, dated 08/17/15, revealed the resident had to wear an</p>	F 282	<p>#7 - "The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common. Refer to the algorithm on page G-6 for assistance in determining the most appropriate self-performance code."</p> <p>Resident #1 has not had any further falls since 6/12/15. Their care plan problem regarding falls was also reviewed and revised as needed on 8/26/15 to reflect accurate interventions. CNA care plan card was also revised on 8/26/15. RN consultant completed audit.</p> <p>All residents have the potential to be affected by this practice.</p> <p>The MDS Coordinators continue to update patient care plans as they are completed quarterly or with the MDS schedule. At that time, the CNA care cards are also updated. Care plans and CNA plan cards will be reflective of current assistance required by patient for ADL care.</p> <p>CNA meetings will be held on 9/24/15, at which time the importance of following the care plan will be discussed. CNA's will also be instructed on where the care plan cards are located and how to get information on the care plan cards updated. Additionally, on 9/10/15 and 9/11/15, CNA's were in-serviced on Falls Reduction by RN consultant and therapy consultant. During this training, CNA care cards were discussed relative to updating, location and adherence to.</p>		

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F 282	Continued From page 15 ace bandage to his/her knee, then would return to normal activities. Interview with Resident #1, on 08/20/15 at 5:00 PM, revealed only one (1) staff had been providing his/her bath at the time of the fall. Interviews with Unit Manager #2, on 08/12/15 at 2:40 PM; and, on 08/13/15 at 3:10 PM, revealed Resident #1 was care planned for two (2) assist because he/she can not roll by himself/herself . Interview with the Director of Nursing (DON), on 08/25/15 at 6:00 PM, revealed the care plan provided should match the care plan. The DON stated staff should follow the care plan. Interview with the Interim Administrator, on 08/25/15 at 5:40 PM, revealed she expected staff to follow facility guidelines, policies, and standards of practice related to the care and interventions provided to the residents. The Interim Administrator further stated she expected staff to act in a manner that ensures the safety and well being of residents.	F 282	Licensed Nurses will be in-serviced on updating and revising care plans post fall, with any change in resident's ADLs and with any physician order change at licensed nurse meetings on 9/21/15. Updating the CNA care plan cards will also be discussed. The DON will conduct meeting. Licensed Nurses were in-serviced on falls reduction on 9/10/15 and 9/11/15 ny the RN consultant and therapy consultant. "Understanding Falls" course has been added for all employees through Relias online learning. Assignment to be completed by 9/30/15. Falls intervention lists were completed by 9/20/15 for each resident by RN MDS coordinators. Unit Managers are completing random observations to assure that interventions listed are in place. Unit Managers started QA monitors after every fall to assure that both care plans and CNA care cards were updated with new intervention relative to fall to be completed on 9/3/15. The DON will compile the data and report to the QA committee monthly until compliance is determined.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Resident #4 discharged on 6/3/15. All residents that receive anticoagulants or any blood thinners including aspirin have the potential to be affected by this practice. All residents that receive anticoagulants or any blood thinners including aspirin had their records reviewed to ensure that monitoring for signs and symptoms of side effects of these medications and monitoring of PT/ INR, if applicable, are included in the resident's care plan beginning 8/26/15 through 9/11/15, conducted by RN consultant and RN unit manager.	10/09/15	

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F 309	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, review of the facility's Nursing Services Policy and Procedure Manual for Long Term Care, 2001 Med-Pass, and review of the Hospital Continuity of Care Document, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of fourteen (14) sampled residents (Resident #4).</p> <p>Resident #4 was hospitalized from 05/04/15 through 05/18/15 for a Heart Catheterization and Stint and was newly admitted to the facility on 05/18/15. The resident received Coumadin (blood thinner) 7.5 milligrams (mg) every day, Brilinta (blood thinner) 90 mg twice a day and Aspirin (blood thinner) 81 mg daily which placed the resident at a higher risk of bleeding; however, there was no evidence the facility developed a care plan to address the needs of the resident due to the increased risk of bleeding. The facility failed to conduct ongoing assessments for signs and symptoms of bleeding (bruising) from 05/21/15 through 06/01/15; and, failed to ensure Resident #4's physician was aware that the hospital physician wanted the resident's International Normalization Ratio (INR) to be between 2.5-3.5 so the dosages could be changed and INR monitored.</p> <p>The findings include:</p> <p>Review of the facility's Nursing Services Policy and Procedure Manual for Long Term Care, 2001 Med-Pass, last revised September 2012,</p>	F 309	<p>Care plan problems or care plan interventions were added as needed.</p> <p>All newly admitted or re-admitted residents since 8/26/15 have had their care plans reviewed to assure that anticoagulant therapy and monitoring for signs and symptoms of side effects of these medications, and monitoring of PT/INR if applicable, were completed. The RN consultant completed the audit.</p> <p>All residents on Coumadin therapy had their chart reviewed to assure that all PT/INRs were obtained as ordered by physician. All lab specimens were obtained as ordered from 8/26/15 to present. The RN consultant completed the audit.</p> <p>The RN Wound Nurse and Unit Manager (RN) completed skin assessments on all residents beginning 9/1/15 and concluding 9/4/15. All areas of skin alterations were noted.</p> <p>The policy to monitor for signs and symptoms of side effects of blood thinning agents will be followed.</p> <p>Monitoring of side effects will be addressed on care plans and will be added to residents medication administration record (MAR).</p> <p>The policy to obtain and report laboratory findings to physicians will be followed. A laboratory log to include dates, specimens obtained, sent to laboratory, report received, reported to physician or physician extender and response was initiated on 8/30/15 on each unit.</p>		

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F 309	<p>Continued From page 17</p> <p>revealed the staff and the physician should monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. The resident should be monitored for excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding.</p> <p>Record review revealed the facility admitted Resident #4 on 05/18/15 with diagnoses which included Congestive Heart Failure, Heart Valve Replacement by Mechanical Device, Paroxysmal Atrial Flutter and Long Term (Current) Use of Anticoagulant (blood thinner).</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/25/15, revealed the facility assessed Resident #4's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) indicating the resident was not interviewable. In addition, the facility assessed Resident #4 as having a diagnosis of Long Term (Current) Use of Anticoagulant (blood thinner) and receiving an anticoagulant seven (7) days during the last seven (7) days.</p> <p>Review of the Admission Physician's Orders, dated 05/18/15, revealed an order for Coumadin 7.5 milligrams (mg) by mouth daily, Brilinta 90 mg by mouth twice daily, Aspirin Enteric Coated (EC) 81 mg by mouth daily and to obtain INR on 05/20/15 with a desired range of 2.5-3.5.</p> <p>Review of the Comprehensive Care Plan for History of Valve Replacement, dated 05/18/15, revealed the care plan addressed Resident #4 was receiving Coumadin; however, the care plan did not address the resident was also receiving</p>	F 309	<p>The policy for licensed nurses to perform a weekly skin assessment on all residents will be followed.</p> <p>In-servicing regarding care plan development and revision with change in residents care will be conducted at licensed nurse meetings on 9/21/15. The DON will conduct meeting.</p> <p>In-servicing of signs and symptoms of side effects of blood thinning medications will be included in licensed nurse meetings on 9/21/15. The DON will conduct meeting.</p> <p>In-servicing on laboratory reporting to physician and maintaining laboratory log will be included in the licensed nurse meetings on 9/21/15. The DON will conduct meeting.</p> <p>In-servicing of performance of weekly skin assessments will be included in the licensed nurse meetings on 9/21/15</p> <p>The Unit Managers will conduct a monitor weekly to ensure that each resident receiving a blood thinning agent has a care plan that addresses this problem and has an intervention to observe for S/S of side effects of these medications. These began 8/30/15.</p> <p>A chart review for all newly admitted or re-admitted patients to ensure that blood thinning medications are care planned and initial skin assessment are performed, was begun 9/4/15 and continues. The Unit Manager reviews the chart after admission and the DON or her designee reviews a second time.</p>		

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F 309	<p>Continued From page 18</p> <p>Brilinta and Aspirin which were also blood thinners and placed the resident at increased risk of bleeding. In addition, there was no intervention to address assessing the resident for signs and symptoms of bleeding due to the increased risk of bleeding or no intervention to address the monitoring of PT/INR levels.</p> <p>Review of the May and June 2015 Medication, Treatment and Task Administration Record revealed the facility administered the resident's Coumadin 7.5 mg every day, Brilinta 90 mg twice daily and Aspirin 81 mg daily from 05/18/15 through 06/01/15. In addition, there was an entry to obtain INR on 05/20/15 with a INR goal of 2.5-3.5 and the INR was obtained on 05/20/15. Further review of the May and June 2015 Medication, Treatment and Task Administration Record revealed there were entries to monitor each shift for side effects of a anxiolytic and an antipsychotic medication; however, there was no entry for monitoring for the side effects of taking the blood thinners.</p> <p>Review of Resident #4's Weekly Skin Assessments, revealed a skin assessment was conducted on 05/20/15; however, there was no evidence any additional skin assessments were conducted from 05/21/15 through 06/02/15 to possibly identify any signs and symptoms of bleeding.</p> <p>Review of Nurse's Notes, dated 05/18/15 through 06/01/15 revealed there was no documented evidence staff were conducting ongoing assessments to identify any symptoms of bleeding.</p> <p>Review of a Laboratory Report, dated 05/20/15,</p>	F 309	<p>The Unit Managers (4), complete a monitor to ensure that the laboratory log is completed appropriately and physicians are notified of laboratory results. This is completed weekly, and began on 9/4/15.</p> <p>The Wound Prevention Nurse (RN) completes a monitor to determine if each residents' weekly skin assessment was completed at time due and any alterations in skin integrity were noted and interventions started as needed.</p> <p>An in-service on Coumadin administration and monitoring was conducted by consultant pharmacist on 9/12/15 for licensed nurses. The Staff Development nurse has completed one on one in-services for those not in attendance.</p> <p>At licensed nurse meetings held on 9/21/15, the following topics will be discussed:</p> <ul style="list-style-type: none"> • Coumadin administration • Coumadin monitoring, including: <ul style="list-style-type: none"> o Laboratory testing (PT/INR) reporting o Signs and Symptoms of side effects of blood thinning agents to be recorded on MAR o Laboratory log use and reporting laboratory results o Care plan development and revision in relation to blood thinning agents o Weekly skin assessment completion and reporting 	
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F 309	<p>Continued From page 19</p> <p>revealed the resident's INR was 2.0 which was below the physician's goal range of 2.5-3.5 with a written notation of "reported", however, there was no documented evidence the facility made the attending physician aware the order read INR goal of 2.5-3.5 and no evidence any action was taken by the physician to address the need of an INR between 2.5-3.5.</p> <p>Further review of the Nursing Notes, dated 06/02/15 at 12:40 AM, 1:00 AM, 1:10 AM, and 1:20 AM revealed the resident began complaining of a headache and the headache continued to worsen; then the resident developed nausea and diaphoresis (sweating). The physician was called and orders were received to send to Emergency Room.</p> <p>Review of a Late Entry Nurse's Note, dated 06/02/15 at 2:00 AM for 06/02/15 at 12:40 AM, revealed the resident had a small amount of dried blood on nose and complained nose felt dry and itchy, will check on humidity for oxygen. No visible signs of bleeding noted.</p> <p>Review of a Nurse's Note, dated 06/02/15 at 4:00 AM, revealed the resident was being transferred to another hospital due to a intracranial bleed.</p> <p>Review of the Hospital Continuity of Care Document revealed the resident Protime (PT) was 87.7 seconds (sec) (normal 13.2-16.3 sec) and the International Normalization Ratio was 9.04 which was critical (measures coagulation time) and the resident was diagnosed with a Intracranial Bleed and Coumadin Toxicity.</p> <p>Interview with Licensed Practical Nurse (LPN) #12, on 08/20/15 at 10:50 AM, revealed she was</p>	F 309	<p>QA monitors for Coumadin care planning began 9/4/15 and are conducted weekly for all residents on blood thinning agents by Unit Managers. The DON completes a QA report and presents to the QA Committee at monthly meetings and will continue until compliance is maintained as determined by committee.</p> <p>QA monitors for lab results monitoring in relation to Coumadin were begun on 9/4/15 and is completed weekly by Unit Managers. The DON will complete the QA report and present to the QA Committee monthly and will continue until compliance is maintained as determined by committee.</p> <p>A QA monitor to assure compliance in completing weekly skin assessments was begun on 9/4/15. Completed by the Wound Prevention Nurse, he/she will compile the information and complete the QA report and present to the QA committee monthly until compliance is maintained as determined by committee.</p>		

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F 309	<p>Continued From page 20</p> <p>working the early morning of 06/02/15 when Resident #4 started complaining of a headache. She stated it wasn't alarming at first but approximately one (1) hour later the resident's head pain had worsened, there was a small amount of dried blood on nasal cannula and the resident was short of breath, diaphoretic and blood pressure was dropping. She revealed the physician was called and orders were received to send the resident to the hospital.</p> <p>Interview with Unit Manager #4, on 08/21/15 at 12:00 PM, revealed she worked as the night supervisor on 06/01-02/15 and she was called just before the resident was sent out to the hospital. She stated Resident #4 was diaphoretic, pulse was weak, skin color was pale and the resident had a nosebleed. She stated she felt the resident had a bleed going on related to his/her symptoms. UM #4 stated resident are showered once a week and receive bed baths daily and Certified Nurse Aides (CNAs) would report any bruising. UM #4 also stated the residents receive skin assessments weekly by a nurse.</p> <p>Interview with LPN #13, on 08/21/15 at 7:50 AM, revealed skin assessments were completed on her shift and they go by the bath list for who to complete skin assessments on. She stated during a skin assessment the resident is checked from head to toe for edema, bruising, and skin breakdown.</p> <p>Interview with LPN #18, on 08/24/15, at 8:30 PM, revealed she did not recall calling Resident #4's physician related to the INR level. She stated she normally would write on the lab slip the physician was notified and stated she can't say that she</p>	F 309			

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F 309	<p>Continued From page 21</p> <p>would have notified him of the hospital's physician goal range.</p> <p>Interview with Resident #4's attending Physician at the hospital, on 08/24/15 at 2:35 PM, revealed if the resident's goal INR level was not obtained he would have increased the Coumadin 10%-15% and rechecked the PT/INR in three (3) days. He stated even if the PT/INR was in therapeutic range on 05/20/15 he would have rechecked the PT/INR in seven (7) to ten (10) days.</p> <p>Interview with the Resident #4's Attending Physician at the facility, on 08/21/15 at 7:05 AM, revealed she did not receive any report on the resident prior to receiving as a patient. She stated she was called on 05/18/15 when the resident was admitted to reconcile the resident's orders and she assessed the resident on 05/21/15. She stated she did not recall being informed of the PT/INR being monitored with a needed goal range. She stated her clinical judgement was to monitor the resident, leave Coumadin at present dose and recheck PT/INR in two (2) weeks; however, further review of the Laboratory Report and the Physician's Orders, revealed there was no order to check the resident's PT/INR in two (2) weeks.</p> <p>Interview with the Medical Director, dated 08/24/15 at 1:00 PM, revealed when a resident PT/INR is stable it is usually checked every month. He stated if there were any changes then he would check the PT/INR in a week and would not have made another adjustment.</p> <p>Interview with MDS Staff #2, on 08/24/15 at 4:33 PM, revealed she was unable to provide an</p>	F 309			

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F 309	Continued From page 22 explanation as to why a care plan was not developed to address the resident's anticoagulants (blood thinners). Interview with the Director of Nursing (DON), on 08/25/15 at 5:30 PM, revealed skin assessments should be completed weekly and if unable to complete the nurse should notify the oncoming shift. The DON stated she expect staff to follow physician's orders for Coumadin monitoring and the resident's care plan should be individualized to match the resident's needs and diagnoses.	F 309			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, review of the facility Post Investigation of Incidents and Post Fall Investigation review and review of the Emergency Medical System (EMS) Patient Care Record, Hospital History of Present Illness, and Acute Care Hospital (ACH) Record, it was determined the facility failed to provide adequate supervision to prevent accidents for two (2) of fourteen (14) sampled residents (Resident #1 and Resident #2). The facility assessed Resident #2 as requiring the	F 323	Resident #1 has not fallen since 6/12/15. Resident #2 has not fallen since 6/21/15. All residents have the potential to be affected by this practice. All residents who have fallen since 8/26/15 have had their fall reviewed by the falls team through root cause analysis to determine the reason for the fall and to put appropriate interventions into place to prevent further falls. The falls team includes the DON, Therapy Coordinator and all 4 unit managers. All residents have had their fall interventions listed for each unit for employee access and review. All these interventions have been added to the care plans, as well as CNA care cards. This was completed on 9/20/15 by MDS coordinators (RN). The incident and accident processes will be followed, as well as, the guidelines for care plan development.	10/09/15	

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F 323	Continued From page 23 assistance of two (2) staff for bathing and bed mobility; however, the care plan did not specify the amount of staff supervision needed for bathing and bed mobility. On 06/21/15, Certified Nurse Aide (CNA) #1 was providing a bed bath for Resident #2 without the adequate supervision of two (2) staff and when CNA #1 turned to obtain a washcloth the resident turned over and fell out of the bed. Resident #2 sustained bilateral nasal bone fractures, a bilateral subarachnoid hemorrhage, and a small subdural hematoma extending along the right temporal frontal region. The facility assessed and care planned Resident #1 as requiring extensive assistance of two (2) staff for bed mobility and total assistance of two (2) staff with bathing; however, on 06/12/15, CNA #2 provided a bed bath for Resident #2 without the assistance of another staff as care planned. Resident #1 fell from the bed when left unattended by CNA #2. Resident #2 sustained bruises and lacerations to hands and knees bilaterally. The findings include: Review of the facility's "Incident and Accident Process", dated 03/01/01, revealed an accident or incident was defined as "any occurrence that is outside the norms of any happening that is not consistent with the routine operation of the center or care of a particular resident. Falls, found on floor, and medication variances were listed as examples of incidents/accidents. Further review revealed when any incident/accident results in an injury, and/or there is evidence of negligence it must be reported to clinical risk management. Injury was defined as any condition requiring medical treatment outside the center that is	F 323	Both residents #1 and #2 have ADL abilities that vary throughout the day and/or from day to day. As per the CMS RAI MDS 3.0 manual, Section G, page G3 Definitions "ADL support provided measures the most support provided by staff over the last seven (7) days, even if that level of support only occurred once. Also, per CMS RAI MDS 3.0 Manual Section G, page G4, coding instructions for each ADL activity bullet points #6 and #7 state: • #6 – "A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.)" • #7 – "The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common. Refer to the algorithm on page G-6 for assistance in determining the most appropriate self-performance code."		

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F 323	<p>Continued From page 24</p> <p>inconsistent with the routine management of the resident's preexisting condition(s), or any event resulting in the resident's admission to the hospital. Further review revealed staff should report the incident/accident; complete an incident report, timeliness is of the essence; report on the shift report, when giving report; on the 24 hour report; and the care plan may require a change/update. Occurrences of an unusual nature will be reported as required by facility policy, and state law.</p> <p>Review of the facility's "Documentation Guidelines, Care Plan Development, last revised 07/03/08, revealed Nursing staff as close to the resident care as possible, Social Worker, Recreation, Dietary, and other disciplines as appropriate for the particular resident were responsible for developing the resident's care plan. The problem should be determined by how the condition affect the resident's well-being (not their partners ability to do their work). The care plan goals may be short-term, long-term, or intermediate goals that should lead to a reasonable attainable objective. The timeframes should be set according to the needs of each individual. Care plan approaches should be specific, individualized steps staff and residents will take together to assist the resident to achieve the goal. Further review revealed the care plans should be updated as needed. In addition, new problems should be handled as they arise, and should be added to the current care plan even if the change in condition is not considered significant enough for a complete revision.</p> <p>1. Record review revealed the facility admitted Resident #2 on 06/30/08 with diagnoses which included Alzheimer's Disease, Arthritis, Late</p>	F 323	<p>A falls team lead by the DON and comprised of Rehab Director and Unit Managers was established on 9/5/15; with training of team on falls prevention, analysis and intervention. This team will begin a root cause analysis process as soon after the fall as possible, preferably beginning with a "post-fall huddle" at fall site. An in depth analysis will continue to be reviewed day after fall, or the Monday after fall, at the Falls Team meeting.</p> <p>Additional resources, such as consultant Pharmacist, Physician, Maintenance Director, Social Worker and any other clinician that may have relevant input must be utilized.</p> <p>The Medical Director attends "5 Star" meeting weekly to again review falls.</p> <p>All falls that have occurred since 8/26/15 have been reviewed and analyzed in this manner.</p> <p>Falls intervention listings per resident have been completed by 9/20/15. These will be kept up to date by each Unit Manager. Each Unit Manager will utilize this intervention list to supervise the CNA's and assure that interventions are in place.</p> <p>All patient care plans will be reviewed and revised as needed to assure all falls prevention interventions and ADL assistance required is accurate, by the MDS Coordinator, nurses, with responsibilities for the resident and CNA with knowledge of the residents' ADL capabilities. The CNA care cards will be reviewed and revised as needed in the same manner, to reflect the care plan data. Both these tasks will be completed for all residents by 9/20/15.</p>	

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F 323	<p>Continued From page 25</p> <p>Effects of Cerebrovascular Disease, Vertebral Artery Syndrome, Insomnia, Depression with Anxiety, and Dementia. Review of the Annual Minimum Data Set (MDS) assessment, dated 04/23/15, revealed the facility assessed Resident #2's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Further review of the MDS assessment, dated 04/23/15, revealed the facility assessed the resident as requiring total assistance of two (2) for bathing and bed mobility which was defined as how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.</p> <p>Review of Resident #2's Comprehensive Care Plan for Activities of Daily Living (ADL's), dated 05/07/15, revealed interventions for staff assistance with bathing, dressing and grooming; however, the care plan did not specify the number of staff needed for bathing, dressing and grooming.</p> <p>Review of Resident #2's August 2015 CNA Care Plan revealed the resident required the assist of two (2) staff for turning and positioning in bed. However, the CNA care plan did not address how many staff was needed for a bed bath which would require turning and positioning the resident.</p> <p>Interview with MDS Staff #2, on 08/24/15 at 4:33 PM, revealed the MDS assessment was used as a guide to develop and revise the comprehensive care plan, and the CNA care plan was made from the Comprehensive Care Plan and they should match at all times. MDS Staff #2 stated the floor nurse comes to the care plan meeting and MDS</p>	F 323	<p>In-servicing on falls reduction was conducted on 9/9/15 and 9/10/15 for all staff, that included falls facts, assessments, and interventions for prevention, root/cause/analysis and data analysis. Additional in-services have been scheduled for 9/22/15b and 9/24/15. These inservices were presented by RN consultant and therapy consultant. One on one in-services will be provided for those not able to attend.</p> <p>During licensed nurse meetings to be held on 9/21/15, the following areas will be discussed by the DON:</p> <ul style="list-style-type: none"> • Falls interventions to match fall "cause" • Falls documentation • Falls intervention log • Care plan development and revision • CNA care cards • Monitoring of falls intervention • Supervision of CNA's utilization <p>During CNA meetings to be held on 9/23/15 review of CNA care card location, revision process and implementation will be reviewed. The DON will be present.</p> <p>All partners have been assigned "Understanding Falls" on Relias on-line Learning, to be completed by 9/30/15.</p> <p>The falls team has met post patient fall since 9/3/15. Falls/data have been analyzed and QA completed to report to QA committee at monthly meeting. The DON or her designee, will analyze this data and complete/present reports. Falls reporting is an ongoing QA to be reported monthly.</p>		

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F 323	<p>Continued From page 26</p> <p>Staff reads off the interventions and the floor nurse reveals if accurate or not. MDS Staff #2 also stated there were several new nurses and there have been issues with the care plans not being updated until the meeting.</p> <p>Review of a Nursing Note, dated 06/21/15 at 10:30 AM, and review of a Post Fall Nursing Assessment, dated 06/22/15, revealed Registered Nurse (RN) #9 was called to the room by CNA #1 and the CNA told the nurse Resident #2 had fallen from bed during his/her bath. The Nurse documented the resident was on his/her right side with his/her right side of face to the floor and there was blood on the floor coming from the resident's nose. Further review of the nursing note revealed when the nurse moved the resident she noted a laceration to the right side of the resident's forehead under the right eye and the nose was visibly disfigured. The resident had a pain rating of four (4) out of ten (10).</p> <p>Review of the Post Investigation of Incidents, dated 06/20/15 (should be 06/21/15) revealed when receiving ADL care the resident used the side rail to roll over during bath and rolled to far and the resident fell in floor.</p> <p>Review of a Post Fall Investigation, dated 06/22/15, revealed Resident #2 fell from bed, with head injury and the new intervention put in place was for two (2) to assist with bed bath. However, according to the MDS assessment the resident was assessed as needing two (2) assist with bathing and turning /repositioning in bed prior to the fall.</p> <p>Review of Emergency Medical System (EMS) Patient Care Record for Resident #2, dated</p>	F 323	<p>During the week of 9/20/15 100% of residents were reviewed to assure falls interventions are in place as indicated by the falls intervention listing. The Unit Managers perform weekly observations and complete the monitor for a minimum of 7 residents per station randomly selected to assure that all applicable interventions are in place as indicated.</p> <p>The DON will compile these monitors and prepare a report for the QA committees review. This will be reported monthly until compliance is maintained, as determined by the QA Committee.</p> <p>The Unit Managers are completing QA monitors to assure that all care plans and CNA care cards are revised after each fall as appropriate.</p> <p>The DON is responsible to compile the monitoring and prepares and presents a QA report to the QA Committee monthly.</p> <p>This will continue until the QA committee determines compliance is maintained.</p> <p>A monitor to determine bed position for those residents with a low bed as falls intervention was begun 9/4/15. The Unit Manager monitors this weekly.</p> <p>The DON will compile this information and prepare and present a report to the QA committee monthly, until the QA committee determines compliance.</p>	

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F 323	<p>Continued From page 27</p> <p>06/21/15 at 10:50 AM, revealed Resident #2 was being given a bath by staff and fell from bed. The resident had a two to three (2-3) inch laceration over the right eye and a two (2) inch laceration under the right eye.</p> <p>Review of Hospital History of Present Illness, dated 06/21/15, revealed Resident #2 received a blow (getting a bath and staff rolled patient on to side and resident continued over striking face on bedside table). Review of a Hospital Computerized Axial Tomography Scan (CT scan) without contrast of Resident #2 head, dated 06/21/15, revealed the resident sustained bilateral nasal bone fractures, a small amount of bilateral subarachnoid hemorrhage, and a small subdural hematoma extending along the right temporal frontal region. Review of the Acute Care Hospital (ACH) Record, dated 06/21/15, revealed Resident #2's final diagnoses was Right Subdural Hematoma, and Traumatic Subarachnoid Hemorrhage. The resident was discharged back to facility on 06/22/15 at 10:10 AM.</p> <p>Interview with Resident #2, on 08/12/15 at 10:30 AM, revealed he/she was being given a bath by CNA #1. The resident stated CNA #1 was standing on his/her left side, and no one was touching him/her and when she turned, he/she went over the right side of the bed, and hurt his/her face so bad he/she had to go to an acute care hospital and stayed for a week.</p> <p>Interview with CNA #1, on 08/22/15 at 1:16 PM, revealed Resident #2 was two (2) assist with activities of daily living but the resident was able to wash the upper part of the body. CNA #1 stated she would get the supplies and fill the basin, then pull the curtains while the resident</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>washed the top part of his/her body and she would give the roommate a bed bath. She stated she would then complete Resident #2's bath by washing the resident's lower body. CNA #1 further stated the day of Resident #2's fall she did not remember if she set her up for the bath or if she gave the whole bath. She stated while she was getting the wash cloth off the bedside table to rinse Resident #2, the resident started to roll to his/her back and she told him/her she was not done and the resident rolled back over and his/her head went up and over the side rail, hit the nightstand, and hit his/her eye and nose on the floor and landed on the right side.</p> <p>Interview with CNA #18, on 08/24/15 at 12:18 PM, revealed she was giving Resident #2's roommate a bed bath with the curtain around the bed and CNA #1 was giving Resident #2 a bed bath. CNA #18 stated CNA #1 had the bed at waist level (three to four {3-4} feet high), and she heard CNA #1 tell Resident #2 to hold on, she was getting a cloth to wash his/her back. CNA #18 stated after that she heard the resident fall.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 08/23/15 at 8:07 PM, revealed when she entered Resident #2's room CNA #1 stated she was bathing Resident #2 and soaped up the resident and when she rolled the resident over to his/her back, the resident's top leg went over the side of the bed and the rest of the resident went too. She stated she was new to the floor and did not know how many staff should be providing a bed bath for Resident #2.</p> <p>Interview with Registered Nurse (RN) #9, on 08/24/15 at 10:40 AM, revealed she was told by CNA #1 that she was giving Resident #2 a bed</p>	F 323		
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F 323	<p>Continued From page 29</p> <p>bath at the time of fall on 06/21/15 and the resident's legs were off the bed. RN #9 stated the CNA said she tried to catch the resident but the resident fell to the floor. RN #2 stated the resident had a nose bleed, and a laceration above and below the eye.</p> <p>Interview with the former Assistant Director of Nursing, on 8/15/15 at 7:36 PM, revealed CNA #1 was the only CNA attending to the resident and had raised the bed up, turned the resident to his/her side, and had turned sideways to retrieve a wash cloth when Resident #2 fell from the bed and received a brain bleed. The former ADON stated she could not remember if Resident #2 required one (1) or two (2) staff for a bed bath.</p> <p>2. Record review revealed the facility admitted Resident #1 on 07/10/13 with diagnoses which included Malaise and Fatigue, Osteoarthritis, Late Effects of Cerebrovascular Disease, Congestive Heart Failure, Neuropathy, and Debility. Review of the Quarterly MDS assessment, dated 04/07/15, revealed the facility assessed Resident #1's cognition as intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) for bed mobility and total assistance of two with bathing.</p> <p>Review of the Comprehensive Care Plan for ADLs, dated 04/15/15, revealed Resident #1 required total care with most ADLs, and to help the resident to bathe, groom, and dress the portions of his/her body that he/she was unable to do; but, it did not specify the number of staff needed for a bed bath that would involve turning and repositioning in bed. Review of the CNA ADL</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>Care Plan revealed the resident required two (2) person care for bathing.</p> <p>Review of the Post Fall Assessment, dated 06/12/15 at 9:50 AM, revealed Resident #1 was turned on his/her right side by CNA#2. The resident fell out of the bed when the CNA left the resident unattended to obtain a wet wash cloth to clean the resident. CNA #2 was providing the bed bath without another staff, which was not per the care plan. Resident #1 was found up on his/her forearms and knees, with bruises to his/her bilateral knees and skin tears to bilateral hands and arms.</p> <p>Review of a Nurse's Notes, dated 06/12/15 at 2:24 PM, revealed staff documented the resident was lying in bed alert with a dressing to the left elbow and right hand. Further review revealed a Nurse's Note, dated 06/12/15 at 10:00 PM, which documented the resident had an ace wrap to the left knee from a fracture due to the fall.</p> <p>Review of the X-ray Report for Resident #1's left knee, dated 06/12/15, revealed there was a non-displaced fibular neck fracture identified. Review of the Physician's Consultation Report, dated 06/17/15, revealed the resident did not have a fracture but was required to wear a ace bandage and was able to return to normal activities.</p> <p>Interview with Resident #1, on 08/20/15 at 5:00 PM, revealed only one (1) staff had been providing his/her bath at the time of the fall.</p> <p>Attempts to interview CNA #2, who was the staff providing care to Resident #1 at the time of fall, on 08/23/15 at 4:40 PM and 08/24/15 at 2:00 PM,</p>	F 323		
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F 323	<p>Continued From page 31</p> <p>were unsuccessful. However, review of a written statement for CNA #2 completed by the prior DON, dated 06/12/15, revealed the CNA was providing a bed bath for Resident #1 without any assistance from other staff. When she turned to obtain a washcloth the resident's legs slipped off the bed resulting in the resident falling out of the bed.</p> <p>Interview with LPN #6, on 08/13/15 at 2:30 PM, revealed Resident #1 fell when CNA #2 rolled the resident over then stepped away to get a wash cloth and the resident's leg flopped over and he/she fell off the bed. LPN #6 stated the resident landed on knees and elbows.</p> <p>Interviews with Unit Manager #2, on 08/12/15 at 2:40 PM and on 08/13/15 at 3:10 PM, revealed Resident #1 was care planned for two (2) assist because he/she can not roll by himself/herself and the CNA was providing care with no assistance. When the CNA went to get a wash cloth, the resident fell out of bed.</p> <p>Interview with the Director of Nursing (DON), on 08/25/15 at 6:00 PM, revealed the nurses update the care plan and it should be updated/ revised at any point that the Plan Of Care changes for a resident. The DON stated the care provided should match the care plan. Further interview with the DON revealed staff should follow the care plan and should not leave residents unattended with bed elevated to ensure the resident's safety.</p> <p>Interview with the Interim Administrator, on 08/25/15 at 5:40 PM, revealed there should be interventions for falls and they should be placed on the care plan. The Interim Administrator stated she expected staff to follow facility</p>	F 323			

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F 323	Continued From page 32 guidelines, policies, and standards of practice related to the care and interventions provided to the residents. The Interim Administrator further stated she expected staff to act in a manner that ensures the safety and well being of residents.	F 323		
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	The facility has posted the staffing on a daily basis as required since 8/26/15. Random observations by partners at various days of the week, at various times of day have been performed since 9/1/15 and continues. The process to post staffing as per federal guidelines will be followed. One on one in-servicing with the Staffing Coordinator on completion and retention of daily staffing form was conducted on 8/31/15 and 9/2/15 by a Staffing Coordinator at a sister facility. An in service on posting requirements and preparation was conducted on 9/2/15, with selected administrative staff for monitoring purposes. This was done by the RN consultant. The staff posting requirements will be reviewed during the licensed nurse meetings to be held on 9/21/15. Posted by the DON A QA monitor has been completed weekly by selected partners to ensure staff were posted. This began 9/1/15 and continues.	10/09/15

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F 356	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to have staffing posted in a prominent place readily accessible to residents and visitors.</p> <p>The findings include:</p> <p>Review of the facility's process for the staff posting, dated 08/24/15, revealed staffing should be posted in accordance with federal guidelines.</p> <p>Observation on 08/07/15 at 11:20 AM, 2:00 PM and 3:50 PM revealed no posting of staffing in the entry to the facility in a prominent place.</p> <p>Interview with Registered Nurse (RN) Consultant #1, on 08/10/15 at 10:38 AM, revealed she had noticed that staffing was not posted on 08/07/15. She stated the Director of Nursing was responsible for ensuring the daily staffing was posted. The RN Consultant stated she had completed the form and given it to the front desk to be posted.</p> <p>Interview with Receptionist #1, on 08/10/15 at 10:35 AM, revealed the RN Consultant had given her the staff posting on Friday (08/07/15) to put up but she did not remember when it was done.</p> <p>Interview with the DON, on 08/10/15 at 10:30 AM, revealed staffing was supposed to be posted every day, and it should be reflective of the actual number of staff.</p> <p>Interview with Interim Administrator, on 08/25/15</p>	F 356	<p>The Staff Development Nurse (LPN) will prepare the report to the QA committee from the monitors completed. This will be reported to the QA committee monthly until compliance is maintained as determined by the QA committee.</p>	
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F 356	Continued From page 34 at 5:40 PM, revealed the staffing should be posted in public at all times.	F 356			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Indoor Air Quality Reference Guide, it was determined the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public related to mold and mildew on Unit #1, Unit #2, and Unit #3 (resident rooms, dining room and day room). The findings include: Interview with the Interim Administration, on 08/25/15 at 9:40 PM, revealed there was no policy for mildew or mold. Review of the Indoor Air Quality (IAQ) Reference Guide Appendix H-Mold and Moisture (http://www.epa.gov/iaq/schools/tfs/guideh.html) revealed mold can grow on virtually any surface, providing moisture is present. Mold can grow on wood, paper, carpet, and foods, when excessive moisture accumulates mold growth will often occur particularly if the moisture problem remains undiscovered or had not been addressed. If mold is discovered, clean up immediately and remove excess water or moisture. Molds produce tiny	F 465	1. Inspection of the dining room known as the "Kettle" reveals that the blackened areas in the wallpaper are part of the design and color scheme of the original wallpaper. The blackened areas noted by surveyors on 8/12/15 are not related to mold or mildew. This is confirmed by comparing samples of new wallpaper from the manufacturer's product catalog with the wallpaper present in the dining room. The samples of new wallpaper have the blackened areas that are part of the color scheme and design. These consistently match the appearance of the existing wallpaper in the dining room. A sample of the new wallpaper is available for inspection and comparison at the facility The leak in the dining room ceiling will be eliminated with the reroofing over this area of the building. Interior work is scheduled to begin 9/21/15 to restore the wood ceilings on Station 1. This work will involve surface cleaning, and repair as required to match existing wood ceiling. The reroofing is expected to be completed by 11/30/15. The interior ceiling restoration will be completed following the completion of the reroofing. 2. Restoration of Room #42 will begin on 9/21/15 and is expected to be completed by 9/26/15. This work will include removal of the vinyl wallcoverings in the room, cleaning of the walls to remove all black substances, surface smoothing and painting.	10/09/15	

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F 465	<p>Continued From page 35</p> <p>spores that waft thru indoor and outdoor continually; when landing on a damp spot they began to grow and digest whatever surface they are on. Molds can produce allergens, toxins, irritants, discoloration and odor problems, deteriorate building materials and lead to health problems—such as asthma and allergic reactions in susceptible individuals.</p> <p>1. Observation of the dining room, on 08/12/15 at 10:20 AM, revealed there were blackened spots on the wallpaper on all four (4) walls from floor to ceiling. Further observation revealed a leak in the ceiling by the ice machine.</p> <p>2. Observation of Room #42, on 08/14/15 at 10:40 AM, revealed a blackened area under the air condition unit and the wallpaper had come loose from the wall under the air conditioner. There was a blackened spotty area behind the wallpaper. Further observation revealed Maintenance Worker #2 pulled the wallpaper back from the wall and closet revealing a blackened spotty area up and down the wall.</p> <p>3. Observation of Nursing Station #1, on 08/10/15 at 12:30 PM, revealed the duct work from the air conditioning unit was leaking and there was a black film on top of the duct work.</p> <p>Interview with Housekeeper #1, on 08/10/15 at 12:30 PM, revealed the duct work always leaked water when it rained, and the black stuff growing on top of the duct work was mold.</p> <p>4. Observation of Room #18, on 08/12/15 at 10:18 AM, revealed there was a very strong musty odor with pink staining showing through the wallpaper and several darkened grayish spots in</p>	F 465	<p>3 HVAC specialists inspected duct work on 9/18/15. No water was present on pipe. HVAC technician reported that if water was previously present due to condensation from duct, the entire pipe would be wet. Roof leak area is noted above duct work and water issue is thought to be from roof in this area. The water leaks around the duct work were particularly noted when it rained outside. This is associated with the roof issues & will be remedied with the reroofing. The surfaces of all the duct work will be cleaned as the restoration of the wood ceiling over the duct work progresses. Ceiling restoration is scheduled to begin 9/21/15 on Station 1. The surfaces of all ductwork on Station 1 will be appropriately cleaned by 10/9/15. In the future, plant operations will perform cleaning of the outer surfaces of the duct work on Station 1 every 6 months to prevent build-up of any dust or other substances.</p> <p>4. Restoration of Room #18 began on 9/14/15 and will be completed on 9/22/15. All vinyl wall covering was removed. The walls were thoroughly cleaned, smoothed and painted. The musty odor in the room completely eliminated.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/25/2015
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW		STREET ADDRESS, CITY, STATE, ZIP CODE 108 HOMEWOOD BLVD. GLASGOW, KY 42141		
(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 465	<p>Continued From page 36 the corner by the window.</p> <p>5. Observation of the day room, on 08/12/15 at 10:15 AM, revealed a whitened dusty area to the day room on the ceiling on both sides.</p> <p>Interview with Unsampled Resident "G", on 08/12/15 at 1:25 PM; and, on 08/19/15 at 10:00 AM, revealed his/her allergies were from the mold and mildew in the room. The resident stated his/her allergies were not bothering him/her until he/she was placed in Room #42. Unsampled Resident G stated Room #42 had a strong odor of mold. The resident stated the facility was supposed to start tearing the wall paper down "today", but he/she had not seen anyone.</p> <p>Interview with Unsampled Resident "H", on 08/12/15 at 2:15 PM, revealed he/she had been moved out of Room #52 because they had raised the wallpaper up and there was mold all in there and you could smell it, and you could smell it coming down the hall.</p> <p>Interview with Housekeeper #6, on 08/12/15 at 10:15 AM, revealed there was mold in the day room, Room #22 smelled musty, and Room #18 smelled real moldy with several darkened areas in the corner of the room. She stated there were also blackened areas on the wallpaper in the dining room that looked like spores up and down all the walls.</p> <p>Interview with Maintenance Worker #1, on 08/12/15 at 8:20 AM, revealed the black spots on the walls in the dining room looked like dirt on the wallpaper all the way to the ceiling, and he did not see any mold or mildew. Further interview with Maintenance Worker #1 revealed he did not have</p>	F 465	<p>5. The whitened dusty areas on the day room wood ceiling on Station 1 are due to roof issues in this area. Work to repair the water damaged areas and to remove the whitened dusty substance on the wood ceiling will begin 9/21/15. This work will involve surface cleaning, and repairs as required to match existing wood ceiling. The interior ceiling restoration will be completed following completion of the reroofing that is expected to be completed by 11/30/15.</p> <p>Unsampled resident "G" has not had any complaints of allergy like symptoms, nor has exhibited any signs or symptoms of allergies since 8/26/15. Unsampled resident "H" resides in a room that is not identified as having "mold".</p> <p>Restoration of Room #18 began on 9/14/15 and will be completed on 9/22/15. All vinyl wall covering was removed. The walls were thoroughly cleaned, smoothed and painted. The musty odor in the room is completely eliminated.</p> <p>Restoration of room #22 is to begin on 9/21/15 and will be completed 9/25/15. All vinyl wall covering will be removed. The walls will be thoroughly cleaned, smoothed and painted, after which the musty odor in the room will be completely gone.</p> <p>The dining room wallpaper is discussed above in #1.</p> <p>During a thunderstorm with heavy rain on 09/11/15, the building was surveyed for roof/ceiling leaks. Leaks were identified in previously mentioned areas on Station 1. No other leaks were identified in other areas of the building.</p>	

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F 465	<p>Continued From page 37</p> <p>any prior knowledge of the dark black, gray spots in the dining room from the floor to the ceiling, and he was not aware of the black covered wall behind the wall paper and under the air conditioning unit in Room #42. Interview with Maintenance Worker #1, on 08/19/15 at 9:45 AM, revealed there were plans to send out for bids related to the mold and mildew for nursing stations 1 and 2, but he did not know if the mold and mildew had been included in the bids.</p> <p>Interview with Maintenance Worker #2, on 08/12/15 at 1:10 PM, revealed there was no way to tell if mold or mildew was in the dining room until the wall paper was taken off. Maintenance Worker #2 stated they had been trying to find leaks and repair them. He stated room #16 and room #32 ceilings had fallen in and it had to be repaired. Maintenance Worker #2 further stated they had to redo two (2) rooms on station #2 because of mold and mildew. He stated the resident in Room #52 had to move out because there was condensation to the outer wall.</p> <p>Interview with the Interim Administrator, on 08/19/15 at 11:25 AM, revealed Corporate and a Contractor (that does a lot of work for corporation) had been to the facility on 08/07/15, and they had a theory that the vinyl wall covering was causing a moisture problem by not allowing the concrete to breathe. The Interim Administrator could not remember when the problem was identified. She stated they had noticed the wallpaper was bubbling and pulling away, and in the last room they had redone there was a black substance but she did not know if it was mildew. Further interview with Interim Administrator on 08/25/15 at 5:40 PM, revealed if mold or mildew was confirmed the facility would</p>	F 465	<p>The facility started a construction/ restoration project on 9/14/2015 to remedy issues associated with moisture in the building. The project is expected to continue through 12/15/2015. The scope of the project will include the following corrections:</p> <ul style="list-style-type: none"> - Reroofing of Stations 1 & 2 of the facility. Inspection of the roof has revealed that new shingles and flashing are required to eliminate interior leaks. This is expected to correct all known ceiling leaks in the facility. The roof project is currently out for bids. Bids are due back from contractors by <p>9/25/15. The roofing work will proceed as soon as possible but will be weather dependent. The roofing project is expected to be completed by 11/30/15.</p> <ul style="list-style-type: none"> - Removal of vinyl wallcoverings, cleaning of the underneath walls, surface smoothing and painting of all exterior walls on Stations 1 & 2. The exterior concrete block walls that are covered with vinyl wall covering have been identified to be retaining moisture. This excess moisture has led to the presence of a black substance underneath the vinyl wall coverings on exterior walls on Station 1 & 2. Four resident rooms per week are being renovated and repaired. A total of 49 resident rooms will require renovation over a 13 week period. 		

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F 465	Continued From page 38 work towards a plan to correct the issue in a timeframe that would be dependent on the scope of the project involved to resolve it.	F 465	<p>- Ceiling repairs, cleaning and refinishing on Station 1 & 2 to correct damage associated with leaks due to the faulty roof. This will include the wood ceiling in common areas on Station 1 (hallway, nurse's station, dining room & day room) as well as plaster ceilings in resident's rooms. The resident room ceilings will be corrected as the walls are restored and painted.</p> <p>The Maintenance/Housekeeping Director has a meeting scheduled on 9/21/15 to discuss the importance of reporting any water leaks, odors and/or discolorations that may be perceived as mold immediately to the supervisors.</p> <p>At the Licensed Nurse meetings scheduled for 9/21/15 and the CNA meetings scheduled for 9/23/15 the importance of reporting odors, water leaks and/or discolorations that may be perceived as mold immediately to the supervisors.</p> <p>Maintenance log book are located on each unit. These books will be monitored weekly by the maintenance director to ensure that all reported issues have been addressed.</p> <p>The maintenance director will complete random checks of resident rooms weekly to ensure that no signs of "mold" or excess moisture are present.</p> <p>The maintenance director began a QA monitor on 9/11/15 regarding mold and water. This will be reported to the QA committee monthly until the committee determines that compliance is maintained.</p>	