

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

PRINTED: 08/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/22/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00022711 and KY00022714 was initiated on 01/21/15 and concluded on 01/22/15. KY00022711 and KY00022714 were unsubstantiated with an unrelated deficiency identified.	F 000			
F 280	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, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure	F 280			

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

TITLE

(X6) DATE

02/13/2015

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 280	<p>Continued From page 1</p> <p>residents' Comprehensive Care Plans were reviewed and revised with interventions to reflect a resident's behavior for (2) of five (5) sampled residents' care plans (Resident's #1 and #4). Resident #1's care plan was not revised after he/she had several documented behavioral episodes, and Resident #2's care plan was not revised to reflect his/her Depression diagnosis and use of Cymbalta (an antidepressant medication).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Nursing Manual, Care Plans-Comprehensive", undated, revealed the facility developed an individualized Comprehensive Care Plan which included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. Continued review of the Policy revealed care plans were revised: as changes in the resident's condition dictated; as new permanent orders were received; as a significant change was assessed; and when desired outcomes were not met, at least quarterly.</p> <p>Review of the facility's policy, titled "Nursing Manual, Behavior Management", undated, revealed residents with behaviors which were problematic/dangerous to themselves or others would be identified and a behavior management plan would be developed in an effort to reduce occurrences of the behaviors. Per the Policy, the Social Worker would develop a care plan for residents with identified problematic behaviors which identified the behaviors, had a measurable goal, had a time frame for evaluation, had specific approaches, and identified personnel</p>	F 280			

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F 280	<p>Continued From page 2 utilizing interventions.</p> <p>1. Review of Resident #1's record revealed the facility admitted the resident on 07/17/14, with diagnoses which included Osteoarthritis, Diabetes and Hypertension. Review of the Social Services Director's (SSD's) Note, dated 11/06/14, revealed Resident #1 was impatient with staff on occasion during the "look back" period, but no behaviors were noted since. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/19/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14), indicating the resident was cognitively intact and assessed to have had no behaviors. Review of Resident #1's Comprehensive Care Plan revealed no documented evidence the resident's behaviors were care planned.</p> <p>Review of a Nurse's Note for Resident #1 dated 11/12/14, revealed Registered Nurse (RN) #1, documented the resident was yelling and screaming at staff to get him/her up, was "demanding and abrupt with staff", and the resident had increased anger when he/she had to wait. Review of a Nurse's Note documented by Licensed Practical Nurse (LPN) #5, dated 11/12/14, revealed Resident #1 had complained of pain and RN #5 provided the resident with a Tylenol per the Physician's Orders. Continued review of the 11/12/14 Note revealed LPN #5 had documented Resident #1 responded when offered the Tylenol by stating, "shove it up your ass hole", then he/she threw the bed controller on the floor.</p> <p>Continued review of the SSD Note, revealed a Note dated 11/13/14, stating the SSD was aware</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>of Resident #1's recent demanding behavior per staff on the floor. The Note revealed the SSD documented Resident #1's mood/behaviors would be monitored.</p> <p>Review of Nurse's Notes revealed RN #1 documented, on 11/14/14, the Psychiatric Physician had performed rounds and a new order was received for Resident #1 for Prozac for the resident's depression. Review of a Note documented by LPN #5, dated 11/20/14, revealed Resident #1 was loud and disruptive in the hallways; yelling and threatening to sue LPN #5 and yelling the nurse was incompetent. Review of the Note documented by LPN #3 revealed Resident #1 was calling LPN #3 incompetent, an imbecile, and stating she did not know her right from her left.</p> <p>Continued review of the SSD's Notes, dated 11/26/14, revealed Resident #1 had a few behavioral outbursts during the current "look back" period, and the Director of Nursing (DON) was aware and would make changes to the staffing. Review of the SSD Note, dated 12/03/14, revealed Resident #1 had a history of verbal behaviors with staff when he/she was upset. Review of the SSD's Note, dated 01/07/15, revealed Resident #1 stated to staff, "pinch my nipple hard and make it hurt", and later told another staff member to "pinch my nipples". Review of the SSD's Note, dated 01/07/15, revealed the SSD documented Resident #1 was referred to psychiatry (psych) regarding his/her behaviors.</p> <p>Review of a "Behavior" Nurse's Note documented by the DON, dated 01/07/15, revealed the Physician and Psychiatrist were aware of</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>Resident #1's inappropriate behaviors, and an order was received to send him/her out to the Emergency Room (ER) for evaluation. Continued review of the Notes revealed Resident #1 was admitted to the hospital behavioral unit on 01/07/15. Review of a Note dated 01/12/15, revealed Resident #1 returned to the facility on 01/12/15, with Seroquel (an antipsychotic medication) prescribed related to his/her behaviors, and Buspirone (an anti-anxiety medication) prescribed as needed for Anxiety.</p> <p>Review of the SSD's Note, dated 01/19/15, revealed Resident #1 refused incontinent care on one (1) occasion during the "look back" period, and she was aware of the resident's suspected physical behavior towards another resident for which an investigation was ongoing. Further review of the Note revealed Resident #1 was to be sent out to the ER for evaluation of the behaviors.</p> <p>Continued review of the Nurse's Note, dated 01/19/15, revealed the DON documented she had discussed Resident #1 and his/her behaviors with the Medical Director who recommended Resident #1 not return to the facility.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #3, on 01/21/15 at 3:58 PM, revealed Resident #1's behaviors included accusing people of stealing from him/her. She revealed the resident requested her to take his/her nipple and squeeze it real hard. She reported staff would work in two's (2's) because the resident would always accuse someone of taking things from him/her. She reported this was not care planned. She stated she reported the resident's behaviors to the charge nurse and the Director of</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>Nursing (DON). She reported the DON would usually just talk to the resident. Continued interview with SRNA #3 revealed she did not believe the talks worked with the resident because he/she would continue with the same behaviors.</p> <p>Interview with SRNA #7, on 01/22/15 at approximately 4:10 PM, revealed Resident #1 was really confused and had always made sexually inappropriate statements to her. She reported he/she would ask the SRNA's to breast feed him/her and to squeeze his/her nipples. She reported she felt uncomfortable taking care of Resident #1 by herself. Continued interview with SRNA #7 revealed the resident's behavior had been going on within the past month. She stated the resident had refused care. He/She refused showers and was "nasty" to all of the aides. She reported those behaviors had been going on for the past couple of months. SRNA #7 reported she believed the DON talked to the resident about his/her behaviors, but (the talk) it did not work. The resident would continue to be nasty to them and continued making inappropriate statements to staff which included asking staff to, "rub down there". SRNA #7 reported she was not certain if the resident's behaviors were care planned, but believed they should have been, adding care plans were very important because the care plan informed staff on how to care for the residents.</p> <p>Interview with LPN #3, on 01/22/15 at 1:09 PM, revealed Resident #1 had behaviors which included manipulating staff to get them to do what he/she wanted to get them to do for him/her. She reported the resident would tell the staff that if they did not do what he/she wanted, then he/she</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>would "get them fired". She reported Resident #1 called her an imbecile and reported to management she had not given him/her a prescribed medication when other staff witnessed her give him/her a medication. She reported she was removed from administering medications to the resident for a while. She stated the resident would often upset the SRNA's and she advised the SRNA's to enter the resident's room with someone else when providing care to the resident. LPN #3 reported she thought Resident #1's behavior should have been care planned with intervention on how to handle these behaviors because he/she could have done or said something that would have gotten staff in trouble.</p> <p>Interview with RN #1, on 01/21/14 at approximately 4:49 PM, revealed the resident had an history of being inappropriate with staff. She reported that if the resident liked staff, he/she was okay. However; if he/she did not like the staff, the resident would give them a hard time. She reported the resident gave LPN #3 a hard time. She stated SRNA #3 and SRNA #7 reported to her the resident was sexually inappropriate with them. RN #1 reported the nursing staff document resident's behaviors if the resident act out and it there was a behavior the resident was experiencing that was not normal for that resident. She reported she believed the resident's behavior would be on his/her comprehensive care plan if he/she was having continuous behaviors.</p> <p>Review of an Acute Plan of Care for Resident #1, dated 01/12/15, revealed the facility had care planned the resident for inappropriate behaviors towards staff. However, further review of the</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>Comprehensive Care Plan revealed no documented evidence it was revised for Resident #1's behaviors other than the Acute Care Plan for his/her behaviors towards staff.</p> <p>Interview with the MDS Coordinator, on 01/22/15 at 4:16 PM, revealed Comprehensive Care plans were completed quarterly or sooner if there was a change in status. The MDS Coordinator reported she completed all of the care plans. and in regards to behavior care plans, the MDS Coordinator revealed the social worker would care plan for resident's behaviors. According to the MDS Coordinator, she was not aware of Resident #1's behaviors prior to the resident going out to the hospital on 01/07/15, when he/she could not control his/her sexual behaviors with women. She reported that if the resident was noncompliant with care and exhibited other behaviors, then the resident should have been care planned for behaviors.</p> <p>Interview with the Social Service Director (SSD), on 01/22/15 at 4:39 PM, revealed she was responsible for completing care plans for residents' behaviors. The SSD reported that when assessing the residents for behavior, she would answer the questions located within the E section of the MDS, if behavior was triggered, she would care plan for it. Continued interview with the SSD revealed she would also ask staff, look at the 24 hour report, and look at the resident's progress notes to see if a resident had a behavior. She reported Resident #1's Comprehensive Care Plan would not have been revised to include a care plan for behaviors because his/her behaviors were isolated. Additionally, she reported isolated meant that the resident's behaviors were not consistent. The</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>SSD reported, after having reviewed Resident #1's record, Resident #1 should have had a care plan in place for his/her repeated behaviors.</p> <p>Interview with the DON, on 01/22/15 at 5:37 PM, revealed that a care plan was revised when there was a change in a resident's status. She reported an acute care plan would be developed. She stated the goal would be to resolve the concern within thirty (30) days, if it was not resolved, then the MDS Coordinator would revise the Comprehensive Care Plan. She stated after review Resident #1's record, Resident #1's care plan should have been revised to reflect the behaviors.</p> <p>Interview with the Administrator, on 01/22/15 at 6:34 PM, revealed it would be his expectation that Resident #1's Comprehensive Care Plan was reviewed and revised regarding his/her behaviors only if the resident had more than "one or two" behaviors. He reported that if the behaviors occurred all the time, then they should have been care planned.</p> <p>2. Review of Resident #4's record revealed, the resident was admitted by the facility on 08/06/14 with diagnoses which included Hypertension and Dementia. Continued review of the resident's record revealed a Physician telephone order, dated 08/19/14, for the resident to receive Cymbalta (anti-depression medication) 30 mg by mouth daily for depression. Review of the resident's Quarterly MDS, dated 11/07/14, revealed he/she had a BIMS of seven (7), which indicated the resident was slightly impaired in cognition and assessed on the MDS for having received an antidepressant within the past seven (7) days of the assessment.</p>	F 280			

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F 280	<p>Continued From page 9</p> <p>Interview with SRNA #6, on 01/22/15 at 4:03 PM, revealed she worked with Resident #4 often, but could not recall if the resident was care planned for depression.</p> <p>Interview with SRNA #7, on 01/22/15 at approximately 4:10 PM, revealed she believed Resident #4 was depressed due to the discord between his/her adult children. She revealed she did not know if the resident was care planned for depression. Further interview revealed the care plan was important because it personalized the resident's care.</p> <p>Interview with LPN #3, on 01/22/15 at 1:09 PM, revealed she had administered Resident #4's medications and was aware the resident was taking Cymbalta. She reported she was not sure why the resident was on Cymbalta. After review the resident's Medication Administration Record (MAR), she reported the resident was taking Cymbalta for pain and depression. She reported the resident should have been care planned for depression.</p> <p>Interview with RN #2, on 01/22/15 at 3:44 PM, revealed she did not know if antidepressants were care planned. She reported a resident with a diagnosis of depression should be care planned. Continued interview with RN #2 revealed Resident #4's comprehensive care plan should have been revised to reflect the resident had a diagnosis of depression.</p> <p>Review of the Comprehensive Care Plan dated 01/21/15 revealed no documented evidence the facility revised the care plan to address Resident #4's depression.</p>	F 280			

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F 280	Continued From page 10 Interview with the MDS Coordinator, on 01/22/15 at 4:16 PM, revealed she captured the resident's antidepressant on the MDS, but failed to care plan for it. She reported she "missed" it. She stated that when the resident returned from the hospital with a diagnosis of depression, the care plan should have been reviewed and revised to reflect his/her prescribed Cymbalta and Depression diagnosis. Interview with the DON, on 01/22/15 at 5:37 PM, when the Cymbalta was ordered, the Physician orders should have been given to the MDS Coordinator. She stated the MDS Coordinator would review the orders and the Comprehensive Care Plan should have been revised. Additionally, she added Resident #4's care plan should have been revised to reflect his/her diagnosis of depression. Interview with the Administrator, on 01/22/15 at 6:34 PM, revealed Resident #4's care plan should have been reviewed and revised to reflect his/her depression diagnoses and prescribed Cymbalta. He stated the Comprehensive Care Plan was important because it was the direction of care of the residents.	F 280			