

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

PRINTED: 01/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/07/2015
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance as alleged on 12/30/14.	{F 000}			

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

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>An Abbreviated Survey investigating KY00022509 and KY00022546 was initiated on 12/03/14 and concluded on 12/08/14. KY00022509 was unsubstantiated with no deficiencies cited. KY00022546 was substantiated with deficiencies identified at the highest Scope and Severity of a "D."</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility</p>	F 280	<p>Resident #1's comprehensive care plan and SRNA care plan were updated by the IDT on 12/2/14. The update includes continuous 1:1 observation twenty four hours per day, an item of interest to hold on to when resident is out of the room, a drink in the cup holder on the wheelchair and do not place resident within arms reach of female peers or vulnerable residents per Serenity Behavior-intervention recommendations.</p> <p>2. All residents receiving 1:1 supervision had the potential to be affected. No other residents are on 1:1 at this time so no other residents were affected.</p> <p>3. A binder was created with the Serenity monitoring sheets to be completed by the 1:1 staff. The 1:1 staff are to document every fifteen minutes the resident's status. The unit manager reviews the sheets daily for compliance. The weekend manager on duty will review the sheets each weekend for compliance. Every shift "Hot Charting" for licensed nurses will</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *John Boser, RN* TITLE: *Administrator* (X6) DATE: *12/31/14*

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F 280 Continued From page 1

failed to revise the Comprehensive Care Plan for one (1) of seven (7) sampled residents (Resident #1).

Resident #1 had a Comprehensive Care Plan for behavior, which was updated on 10/27/14 after the resident was alleged to have touched a female resident's breast. The care plan included an intervention for one on one (1:1) supervision of Resident #1; however, the care plan was not revised when changes to the 1:1 supervision were initiated. In addition, the facility failed to ensure the care plan was revised to include specific environmental interventions recommended by a Behavior Consultant, which included staff not placing Resident #1 within arm's reach of vulnerable female peers as much as possible.

The findings include:

Review of the facility's policy titled "Care Plans-Comprehensive", revised date October 2010, revealed an individualized care plan to meet each resident's medical, nursing, mental, and psychosocial needs was to be developed. Further review of the Policy revealed the care planning interdisciplinary team was responsible to review and update the care plan when a significant change in the resident's condition was identified and interventions were to be developed that targeted the problems.

Review of Resident #1's medical record revealed the facility admitted the resident initially on 02/24/10, and re-admitted him/her on 06/14/13, with diagnoses which included Anxiety State, Severe Dementia, Difficulty in Walking and Muscle Weakness. Review of the Minimum Data

F 280

continue and not be removed. On 12/5/14 through 12/7/14 100% of the facility staff were in serviced on Resident #1's interventions, care plan update and serenity in services. The employee roster was used to track and validate attendance.

4. Resident #1 was discussed in the QA meeting of December 7, 2014. The on-going plan of care was reviewed. This review will continue until Resident #1's behaviors subside or Resident #1 no longer resides in the facility. The DON will be responsible for overseeing compliance with this regulation.

Date of completion: 12/10/14

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F 280	<p>Continued From page 2</p> <p>Set (MDS) Assessment, dated 11/09/14, revealed the facility assessed Resident #1 to be severely cognitively impaired.</p> <p>Review of an assessment/evaluation performed by a Behavioral Health Consultant, dated 11/02/14, revealed Resident #1 engaged in Pica-like behavior and inappropriate grabbing of items not belonging to him/her (Pica is defined as ingestion of nonedible items or substances). Continued review of the assessment/evaluation revealed Resident #1's behaviors included "reaching out for one's breasts", putting his/her "hand up one's shirt or down one's pants, or pinching their sides". Further review of the document revealed recommended "environmental manipulations" which included: a cup holder and cup placed on the resident's wheelchair; a bag which contained items to hold when the resident was out of his/her room; and preferred finger foods available in a bowl with him/her. In addition, review revealed to reduce "sexual grabbing" Resident #1 was not to be placed within "arm's reach of female peers" or vulnerable residents as much as possible; and to "slowly decrease" the twenty-four (24) hour 1:1 monitoring when a decline in the "challenging behaviors" was noted.</p> <p>Review of a document provided by the facility, which had a timeline of 1:1 monitoring intervals, revealed Resident #1 was monitored 1:1 by staff on all shifts starting on 10/27/14. Further review of the document revealed 1:1 monitoring was changed starting on 11/03/14, to monitor Resident #1 only from 7:00 AM to 11:00 PM, and on 11/08/14, the monitoring was again changed to monitor the resident only from 3:00 PM to 11:00 PM.</p>	F 280			

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F 280 Continued From page 3

F 280

Review of Resident #1's Comprehensive Care Plan revealed the resident had a behavior care plan, dated 09/30/14, related to a history of behaviors which included consumption of nonedible products (Pica). Continued review of the care plan revealed it was updated/revised on 10/27/14, related to an allegation the resident had attempted to touch a female resident's breast. Continued review of the behavior care plan revealed the related interventions on 10/27/14 included only 1:1 supervision, diagnostic tests, use of diversion techniques when the resident was trying to grab objects, and to transfer to a psychiatric facility for evaluation. However, further review revealed no documented evidence the care plan was revised or updated for the following: when the 1:1 monitoring times were reduced or discontinued; availability of specific diversion items; nor an intervention to attempt to keep the resident out of arms reach of female/vulnerable residents as recommended by the Behavioral Consultant.

Interview with Licensed Practical Nurse (LPN) #1, on 12/05/14 at 3:13 PM, revealed she took care of Resident #1 at times and the purpose of the care plan (behavior) was to know what was supposed to be done if Resident #1 had behaviors, which included grabbing. LPN #1 revealed behavioral interventions included 1:1 monitoring of Resident #1 which initially was twenty-four (24) hour monitoring, but later changed to monitoring on only certain shifts. She stated putting a cup on his/her wheelchair was another change. LPN #1 also revealed she was unaware staff were to try and ensure the resident was kept out of arm's reach of female residents or other residents. She further stated Resident

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F 280	Continued From page 4 #1's behavior care plan was unclear and if she was a new nurse she would not know what was to be done based on review of the care plan. Interview with LPN #4, on 12/05/14 at 12:55 PM and 3:36 PM, revealed she cared for Resident #1 routinely, and the resident's care needs were care planned. LPN #4 revealed the care plan had 1:1 monitoring initiated on 10/27/14, but it was not revised when subsequent changes in the monitoring schedule were initiated and when the 1:1 monitoring was discontinued. In addition, LPN #4 stated the monitoring intervals after the resident was taken off 1:1 monitoring were not on the care plan, and this was not made clear to staff. Interview with Registered Nurse (RN) #3/Unit Manager (UM), on 12/05/14 at 3:55 PM and on 12/08/14 at 11:23 AM, revealed the purpose of residents' care plans was to ensure staff were on the "same page" in terms of providing care for that resident. RN #3/UM stated Resident #1's behavior care plan was not revised to show the changes in 1:1 monitoring intervals and other monitoring documentation. She indicated the care plan should have been revised to include this information. Continued interview revealed Resident #1's behavior care plan did not include an intervention for staff to attempt to ensure the resident was kept out of arms reach of female residents, and stated the intervention should have been included. Interview with the RN #4/MDS Coordinator, on 12/05/14 at 1:05 PM and on 12/08/14 at 12:10 PM, revealed it was important to ensure the residents' care plans were updated so staff caring for each resident would be able to reference	F 280			

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F 280 : Continued From page 5

his/her care needs. RN #4/MDS Coordinator stated Resident #1's Comprehensive Care Plan had not been updated/ revised to include the behavior interventions recommended by the Behavior Specialist for the resident and for the changes in 1:1 monitoring. She revealed she "assumed", if interventions were not ordered, the Social Worker (SW) was supposed to revise/update the care plan when behavioral interventions were discussed at morning meetings.

Interview with the SW, on 12/08/14 at 11:29 AM and 3:32 PM, revealed she updated residents' behavior care plans quarterly; however, if a resident experienced an acute change in behaviors, then nursing or the SW could update the care plan. She revealed Resident #1's behavior care plan was supposed to be updated with the "environmental manipulations" recommended by the Behavior Specialist, but there was a communication breakdown related to who was supposed to perform the update. Continued interview revealed nursing staff were supposed to update the monitoring intervals on the behavior care plans.

Interview with the Director of Nursing (DON), on 12/04/14 at 4:14 PM, revealed Resident #1 had Pica-like/inappropriate grabbing behaviors and the facility had tried to identify reasons for the behaviors. She stated the facility had interventions in place, such as tool belt as the resident had worked in maintenance, magazine or puzzles, or anything which kept Resident #1 busy. The DON revealed the facility had also made changes in Resident #1's medications. Continued interview revealed the nursing assistants were educated on why Resident #1

F 280

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F 280	Continued From page 6 was placed on the 1:1 monitoring, and were given instructions to keep the resident out out reach of female residents. She further stated Resident #1 also had sitters; therefore, the monitoring intervals were decreased. Interview with the Administrator and the RN Consultant (RNC), on 12/08/14 at 2:31 PM, revealed Resident #1's care plan should have been updated/revised with the recommendations made by the Behavior Specialist, and when the behavior monitoring intervals had changed. During continued interview, the RNC stated the expectation was for the SW to be responsible for updating Resident #1's behavior care plan. She further stated the DON or the Staff Development Coordinator were supposed to ensure the care plan was updated/revised when condition changes occurred.	F 280		
F 323 SS=D	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 and review of the facility's policy, it was determined the facility failed to ensure one (1) of seven (7) sampled residents (Resident #1) received adequate supervision/monitoring related to behaviors.	F 323	Resident #1 was placed back on continuous 1:1 on 12/4/14. 1:1 staffing will not be removed until assessment of Resident #1 shows behaviors have subsided or resident#1 is no longer in the facility. 2. There are no other residents requiring 1:1 supervision, therefore, no other residents were affected. 3. Staff assigned to 1:1 with Resident #1 will document every fifteen minutes while attending the resident. The unit manager will review the 1:1 sheets daily for compliance. On weekends,	

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F 323 Continued From page 7

Resident #1 had grabbing behaviors and was alleged to have touched a female resident's breast on 10/26/14. The facility initiated a behavior monitoring plan which included the observation and documentation of identified behaviors at timed intervals, on a behavior-specific sheet. When Resident #1 progressed from one to one (1:1) staff supervision/fifteen (15) minute checks to every thirty (30) minute checks, interviews and record review revealed staff failed to observe and document Resident #1's behaviors according to the timeframes determined by the facility.

The findings include:

Review of the facility's policy titled "Safety and Supervision of Residents", revised date December 2007, revealed resident safety and supervision were facility-wide priorities. Further review of the policy revealed targeted interventions to reduce accident risks/hazards were to be communicated to relevant staff, implemented and documented.

Medical record review revealed the facility admitted Resident #1 initially on 02/24/10 and re-admitted the resident on 06/14/13, with diagnoses which included Severe Dementia and Anxiety State. Review of the Minimum Data Set (MDS) Assessment, dated 11/09/14, revealed the facility assessed Resident #1 to have severe cognitive impairment.

Review of Resident #1's Comprehensive Care Plan revealed a behavior care plan which indicated the resident had a history of behaviors, including the consumption of nonedible products

F 323;

the Manager on Duty will verify compliance. From 12/5/14 until 12/7/14, 100% of the staff were in service on the Serenity in service and safety and supervision of residents as well as the care plan interventions and changes made to Resident #1. The tracking of the in service was done through current employee roster.

4. The plan of care and monitoring sheets will be taken to the QA committee meeting each month for review. This will continue until Resident #1's behaviors subside or the resident no longer resides in the facility. The DON will be responsible for ensuring compliance with this regulation.

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F 323	<p>Continued From page 8</p> <p>(Pica). On 10/27/14, the behavior care plan was updated to reflect an alleged incident related to Resident #1's touching of a female resident's breast. Further review of the behavior care plan revealed Resident #1 was placed on 1:1 supervision at that time.</p> <p>Review of the Behavioral Health Consultant's assessment/evaluation of Resident #1's behaviors, dated 11/02/14, revealed the resident engaged in Pica-like behavior and inappropriate grabbing of items not belonging to the resident. Continued review revealed Resident #1's inappropriate grabbing included reaching for others breasts, putting his/her hand up another resident's shirt or down their pants. Further review of the assessment revealed to reduce "sexual grabbing", the Behavioral Health Consultant recommended Resident #1 was not to be placed within arm's reach of female peers or vulnerable residents as much as possible. Additionally, the Behavioral Health Consultant recommended a planned decrease of the 1:1 monitoring of Resident #1 as decreased behaviors were observed.</p> <p>Review of training records revealed an inservice titled "Identifying Types of Behaviors, Documentation and Reporting", was provided on 11/07/14. Continued review revealed training topics included documentation by staff on the "Behaviors of Interest" form. Further review revealed the facility documented which staff attended the inservice.</p> <p>Review of the "Behaviors of Interest" form for Resident #1, revealed staff were to document if the resident did or did not exhibit Pica-like behaviors or inappropriate grabbing during</p>	F 323	

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F 323	<p>Continued From page 9</p> <p>timed-interval monitoring. Continued review revealed the form was marked for monitoring at fifteen (15) minute intervals.</p> <p>Review of the facility's communication tool titled "Hot Charting", dated 11/17/14, revealed staff were to monitor Resident #1's behaviors and complete the behavior form every fifteen (15) minutes from 3:00 PM to 11:00 PM, and every thirty (30) minutes from 11:00 PM to 3:00 PM.</p> <p>Interview with the Director of Nursing (DON), on 12/04/14 at 4:14 PM and 12/05/14 at 10:18 AM, revealed the facility utilized behavior check off sheets to monitor Resident #1's behaviors. She stated if a behavior occurred, staff were to document it on the form. The DON revealed staff had been inserviced on what behaviors to observe, and were to document on the form at 15 (fifteen) or thirty (30) minute intervals, according to the time of day. The DON further stated the interdisciplinary team reviewed the behavior check sheets daily to identify any observed behaviors and determined the appropriate supervision needed.</p> <p>Further review of the "Behavior of Interest" sheets for Resident #1 revealed no documented evidence the resident was monitored for behaviors during the following times/dates: 11/18/14 from 7:00 AM to 3:30 PM; 11/21/14 after 12:00 PM; 11/22/14 from 7:00 AM to 3:30 PM; and the dates of 11/24/14, 11/25/14, and 11/26/14.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 12/04/14 at 3:46 PM and on 12/06/14 at 4:09 PM, revealed she routinely sat one on one with Resident #1 on the evening shift and</p>	F 323		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/08/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323 Continued From page 10

documented any behaviors observed at fifteen (15) minute monitor intervals. CNA #5 revealed she was unable to recall attending an inservice regarding Resident #1's behaviors and when the one on one monitoring was stopped she was unaware of any other special monitoring.

Interview with Licensed Practical Nurse (LPN) #4, on 12/05/14 at 3:36 PM and on 12/08/14 at 12:29 PM, revealed she took care of Resident #1 routinely and had not been inserviced on the resident's behavior. LPN #4 revealed the "Hot Listing" communicated the behavior monitoring intervals to staff and the one on one monitoring was discontinued on 11/23/14. LPN #4 further revealed when the resident was monitored one on one by the aides they documented on the behavior monitor sheet every fifteen (15) minutes. However, the LPN stated she was not sure who was supposed to document the thirty (30) minute checks because it was not made clear to staff.

Interview with LPN #3, on 12/08/14 at 1:00 PM, revealed the 11/17/14 "Hot Charting" indicated Resident #1 behaviors were to be monitored every fifteen (15) minutes from 3:00 PM to 11:00 PM and every thirty (30) minutes from 11:00 PM through 3:00 PM, once the resident was taken off one on one monitoring. LPN #3 further revealed the behavior sheets were to be utilized and documented at thirty (30) minute intervals on the dates of 11/24/14 through 11/26/14.

Interview with Registered Nurse (RN) #3/Unit Manager, on 12/05/14 at 3:55 PM and on 12/08/14 at 11:23 AM, revealed staff were supposed to have been inserviced on behaviors and documentation so everyone was "on the same page"; however, she revealed she had not

F 323

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

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F 323 Continued From page 11

attended the inservice and no one had discussed the inservice with her. Continued interview revealed changes to the monitoring of Resident #1 were placed on the "Hot Charting" sheet. RN #3/Unit Manager explained the facility's behavior monitoring process was for staff to document on the behavior sheet every fifteen (15) minutes when a resident was on one to one monitoring, and progress to every thirty (30) minute monitoring. She further stated she was not sure why there was a breakdown in the monitoring system, resulting in Resident #1 not being monitored according to the facility's plan. Continued interview revealed she collected the behavioral sheets, but was not aware who was responsible for reviewing the sheets. She acknowledged someone should have ensured the resident was being monitored as directed.

Interview with the Administrator and the Nurse Consultant (NC), on 12/08/14 at 2:31 PM, revealed training related to behavior monitoring and documentation was provided on 11/07/14, and the inservice information was passed on to the DON. Continued interview revealed the Administrator and the NC had assumed all staff had been inserviced. The NC stated the monitoring of Resident #1, based on review of the monitoring sheets, was titrated down from one to one monitoring and discontinued on 11/23/14. The NC acknowledged when the resident was no longer one to one monitoring, staff were to monitor behaviors every thirty (30) minutes, but this was not done. In addition, the NC revealed the DON gave the instructions, and the Unit Manager was to go out and implement them. She stated the DON and Unit Manager were responsible to make sure the resident was monitored as directed, but there was a

F 323

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323 Continued From page 12
breakdown because no one reviewed the documentation or followed up to ensure staff implemented the monitoring plan fully.

F 520 483.75(o)(1) QAA
SS=D COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

F 323

F 520

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policies and Plan of Correction (POC) for the Standard Survey completed on 06/30/14, it

1. The Quality Assurance Committee met on December 7 and December 10, 2014 to discuss the updated care plan and interventions for Resident #1.
2. No other residents were affected.
3. The Quality Assurance Committee is now chaired by the facility administrator and meets bi-weekly. A new process for updating care plans was discussed and approved by the QA committee on 12/10/14. The process for ensuring the care plan is updated is a three step process. The 11-7 nurse checks the physician order each night to the Medication Administration (MAR) for accuracy. The nurse initials the order and places it in the unit managers box. The unit manager

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520 Continued From page 13
was determined the facility failed to maintain an effective Quality Assessment and Assurance (QA) Program to ensure the facility's POC to address the cited deficiencies was implemented, monitored, evaluated and revised to ensure ongoing compliance was maintained. This was evidenced by a repeat deficiency related to the facility's failure to ensure revision of care plans for one (1) of seven (7) sampled residents (Resident #1). The facility failed to ensure Resident #1's Comprehensive Care Plan was updated/revised with newly-initiated behavior interventions. (see F280)

The findings include:

Review of the facility's policy titled "Performance Improvement Plan", revised March 2010, revealed the facility conducted an on-going Performance Improvement (PI) program designed to systematically monitor and evaluate the appropriateness of resident care, resolve identified problems, and identify opportunities for improvement. Continued review of the Policy revealed the PI Committee had the responsibility for designing and implementing corrective action plans as needed to resolve identified resident care/service problems.

Review of the facility's POC with a compliance date of 09/27/14, for the citation at F280 regarding revision of residents' care plans, revealed education was provided on 08/14/14 to the Minimum Data Set Nurse (MDSN), Assistant Director of Nursing (ADON) and Social Services Director (SSD) on the facility's policies and procedures for the residents' Comprehensive Care Plans, including revision of the care plans. Continued review of the POC revealed the facility

F 520
compares the order with the MAR and then the care plan to ensure care plan update was completed. The unit manager initials the order and gives to the MDS nurse. The MDS nurse checks the order for accuracy and the care plan to ensure it was updated and accurate. The DON is then given copies of the order with three initials indicating that all checks are complete. If the order does not have three initials, the DON will investigate and address accordingly.

4. A quality assurance audit will be completed by the Director of Nursing or ADON of ten orders weekly to ensure that care plans are updated per protocol. The DON will bring the results of tracking and trending to the monthly QA meeting for further recommendations and or resolutions. The DON will be responsible for compliance with this regulation.

Date of completion: 12/30/14

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F 520	Continued From page 14 was to monitor care plans as necessary at the daily clinical meeting to initiate, review and/or revise care plans as needed for change of condition in residents. Review of Resident #1's medical record and the Comprehensive Care Plan revealed the care plan related to behaviors was not updated/ revised to include the environmental "manipulation" interventions recommended by a Behavioral Health Consultant the facility had consulted for the residents. Review of the Behavioral Health Consultant's documentation revealed the recommended interventions included: a cup holder and cup to be placed on the resident's wheelchair; a bag to contain items for the resident to hold when he/she was out of his/her room; and the availability of preferred finger foods in a bowl with the resident. Continued review revealed to reduce "sexual grabbing", the resident was not to be placed within arm's reach of female peers as much as possible, and changes were to be made to the one on one (1:1) monitoring instructions when the resident's behaviors decreased. Interview with Registered Nurse (RN) #4/MDS Coordinator, on 12/05/14 at 1:05 PM and on 12/08/14 at 12:10 PM, revealed the behavior interventions recommended for Resident #1, and the changes to the one on one monitoring, were not updated on care plan. She stated she assumed the Social Worker was supposed to update the care plan if behavioral interventions were discussed at morning meetings. Interview with the Social Worker, on 12/08/14 at 11:29 AM and 3:32 PM, revealed Resident #1's behavior care plan should have been updated with the environmental manipulations	F 520			

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

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F 520	<p>Continued From page 15</p> <p>recommended by the Behavior Specialist, but there was a communication breakdown related regarding who was responsible for performing the updates. In addition, the Social Worker stated nursing should have updated the monitoring intervals on the care plan.</p> <p>Interview with the facility Administrator and the Registered Nurse Consultant (RNC) on 12/08/14 at 2:31 PM, revealed per the POC, care plan revisions were made at the morning clinical meetings based on changes in a resident's condition, on an ongoing basis. The RNC stated the facility utilized a tool, the white board, which was reviewed at the morning meetings to ensure care plans were revised with condition changes, with the revision dates documented on the board. The RNC acknowledged the interdisciplinary team had not updated Resident #1's care plan, and neither the DON or the Staff Development Coordinator had followed up to ensure the care plans were revised as needed.</p>	F 520		