

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

PRINTED: 05/21/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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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 000}	INITIAL COMMENTS  AMENDED 05/21/12 (Under the initial comments section of the SOD - corrected the IJ removal date, as well as the acceptable AOC "received" date. Additionally, corrected the abbreviated survey "concluded" date to 03/22/12 in each deficient practice statement)  On 04/10/12, an onsite revisit to the abbreviated survey was conducted which determined Immediate Jeopardy (IJ) had been removed at F-223, F-225, F-226, F-250, F-280, F-282, F-323, F-365, F-490, and F-520 on 03/30/12, as alleged in the acceptable Allegation of Compliance (AOC), received on 04/05/12. While the IJ was removed at F-223, F-225, F-226, F-250, F-280, F-282, F-323, F-365, F-490, and F-520, continued non-compliance remained as follows: F-280, F-323, F-490 and F-520 at a S/S of an "E" and F-223, F-225, F-226, F-250, F-282, and F-365 at a S/S of a "D". The facility's Quality Assessment and Assurance Committee had not completed staff monitoring, analysis of information, nor had the opportunity to develop and implement a plan to ensure correction of the deficient practice to prevent non-compliance recurrence.	{F 000}	DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Dawson Pointe, d/b/a Dawson Springs Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Dawson Springs Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Dawson Springs Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.	
{F 223} SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	{F 223}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE 5-25-12

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  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
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{F 223}	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to resident to resident abuse. However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and the facility had not had an opportunity to develop and implement a Plan of Correction (POC), as related to abuse prevention, identification, intervention, and reporting.  The findings include:  Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed the Corporate Compliance Nurse and facility Administrator provided an in-service on 03/21/12 for the Administrative nurses, the Social Services Director, and other facility Supervisors/ Department leaders with the focus being the facility's Abuse, Neglect, and Exploitation Policy with in-depth coverage on abuse recognition, reporting allegations and incidents, appropriate interventions, and the investigation process. All remaining staff and new hires were in-serviced by 03/22/12. Nurse aide rounds, in-serviced and initiated on 03/21/12, were completed every hour with a designated sheet for documentation and reporting to the charge nurse. The facility cited the reason was to view residents frequently, know	{F 223}	<b>F223</b> <b>Residents #1, #4, #5, #6, and #7</b>  <b>1. Corrective Actions:</b>  Administrator confirmed with staff consultation (DON, Administrative Nurses and Corporate Compliance Nurse) and record review that any corrective action needed for these identified residents was completed and documented by March 29, 2012:  Residents #4 & 5 were fully assessed by Charge Nurse on February 19, 2012; family and physician notified and care plans up-dated.  Resident #6 & # 7 were moved to other rooms away from resident # 1, 2-21-12 and 12-7-11, by Social Services Director and DON.  Resident #1 was placed on one to one supervision on 2-19-12 while at the facility until transferred for mental health treatment in a psychiatric hospital setting. At the time of the psychiatric hospital discharge, the resident was no longer exhibiting agitation or aggression per the discharge summary. One to one supervision was again initiated by DON on March 16, 2012, in an effort to assure that no resident would be affected by Resident #1.		

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{F 223}	Continued From page 2 their whereabouts, and assess the environment for accident hazards and maintaining a safe environment. Additionally, the hourly rounds included observing for indicators of abuse or potential abuse. The charge nurses conducted compliance rounds twice each shift to observe for indicators of abuse and to confirm a safe environment. Documentation of the compliance rounds was in a check sheet format and any items identified were addressed immediately with a written report that was passed on to the DON, who reports to the Administrator, who reports to Corporate Compliance Nurse. A system for daily monitoring of incident reports covers 7 days a week and was reviewed by Administrative nurses with any problems immediately passed on to the Administrator and Corporate Compliance Nurse.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).	{F 223}	Resident #1 was assessed by the MDS Coordinator and Social Services Director, utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities on March 29, 2012.  Care plans were reviewed and revised for Residents # 1, 4, 5, 6 and 7 by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows:  #1 Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident #4 Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard #5 Diversional activities revised to include coloring, puzzles, and TV #6 Revised care plan on making false accusations, revised potential for verbal abuse to include behavior activity box, and conversation #7 Changed diversional activities to conversing, TV, games and personalized activity box  MDS Coordinator and Social Services Director reviewed and revised Behavior Observation Program (BOP)	
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	{F 225}		

F223 Continued

3a

sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)*

**2. ID of others at risk:**

All residents could be considered potentially at risk for abuse, however, all residents were assessed by Licensed Nursing Staff on 3-21-12 utilizing observation and interview with no other residents identified as being mistreated, abused, or any resident showing signs of distress. *(See Residents at Risk for Abuse Assessment form, Attachment #5.)*

**3. Prevention measures:**

Inservice was held on March 21, 2012, for all Administrative Nurses (including two Charge Nurses), Social Services Director, Administrator, and other Supervisory and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related

F223 Continued

3b

to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse and the Administrator. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse, and how to identify events and initiate an investigation including who, when, and how to report.

ALL staff inserviced by March 22, 2012 on the Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, with the initial inservice provided by the Corporate Compliance Nurse and any remaining persons were inserviced by the Administrator, DON, or Administrative Staff (Administrative Nurse, RN Charge Nurse, Social Services Director) on an individual basis prior to their next shift. All new hires receive same training in initial Corporate orientation with Corporate Nurse Trainer. *(See Abuse Policy and Inservice Record, Attachment #2 thru 2h)*

Nurse aide rounds are in place every hour and documentation initiated by DON on March 21, 2012 to view residents frequently, know their whereabouts, assess the environment for accident hazards and maintaining a safe environment. This includes observing for signs of abuse or potential abuse situations. Charge Nurses

F223 Continued

3c

were inserviced by DON on NASR rounds' documentation on March 21, 2012. All NASR's and NA's educated on the documentation requirements for Nurse Aide Rounds at the beginning of each shift by their Charge Nurse. *(See NASR documentation forms and Inservice Record, Attachment #3 thru 3e)*

Corporate Compliance Nurse trained administrator March 21, 2012, that all alleged violations involving mistreatment, neglect or abuse must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting. Corporate Compliance Nurse trained Administrator regarding residents' right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. There must be evidence that residents are protected from abuse and all alleged violations are thoroughly investigated and the facility must prevent potential abuse verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion) of any resident. *(See Corporate Compliance Nurse Record of Inservice Training for ADM Documentation Form, Attachment #4.)*

F223 Continued

3d

Inservice for all Nursing Staff on March 28, 2012 provided by MDS Coordinator, Compliance Nurse and DON regarding implementation of suggestions and interventions for behaviors to be utilized through the Behavior Observation Program to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment when behaviors are exhibited by residents. If unsuccessful, Charge Nurse will be notified to assess for 1:1 supervision. *(See Inservice Training Record r/t Behavior Management, Attachment # 4a)*

ALL staff inserviced on Behavior Observation and Suggested Interventions by DON, Administrative Nurse, and MDS Coordinator on March 29, 2012. Any staff members not in attendance inserviced by Administrative Staff (Administrator, DON, Administrative Nurse, or RN Charge Nurse,) on an individual basis prior to their next shift. All new hires receive same training in initial orientation by Corporate Nurse Trainer.

All staff were made aware in March 29, 2012, training of the immediate jeopardy concerns cited by the OIG on March 21, 2012. *(See Inservice Training Record r/t Behavior Management, Attachment # 4b thru 4m)*

Social Services Director has been provided with additional training utilizing "The New

F223 Continued

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Care Plan Answer Book for Activity, Psychosocial and Social Work Programs" by Esther J. Davis, BS, CTRS; Steven C. Greenwald, MSW, LCSW, ACSW and Traci Pareti, CTRS; ordered March 22, 2012, by the Administrator and presented and reviewed with the the Social Services Director on March 29, 2012. The MDS Coordinator and the DON worked with the Social Services Director in on the job training reviewing and rewriting care plan approaches and interventions for behaviors on March 29, 2012. *(See Attachments #13 and #13a)*

#### 4. Monitoring

Nurse aide rounds are in place every hour and documentation initiated on March 21, 2012 to view residents frequently, know their whereabouts, assess the environment for accident hazards and maintaining a safe environment. This includes observing for signs of abuse or potential abusive situations. Charge Nurses were inserviced on NASR rounds' documentation on March 21, 2012, by the DON. All NASR's and NA's educated on the documentation requirements at the beginning of each shift by their Charge Nurse. Any issues are corrected and reported to the Charge Nurse immediately. The NASR documents are given to Charge Nurse for review at the end of each shift. The Charge Nurse reports information from the rounds in their report to the DON or Administrative Nurse daily including

**F223 Continued**

weekends. The DON reports any problems to the Administrator and the Administrator reports findings to the Corporate Compliance Nurse daily, including weekends and holidays for 30 days and then weekly. *(See Attachment #3, NASR Rounds and Charge Nurse Rounds Form, Attachment #6.)*

Compliance rounds are completed by Charge Nurses two times per shift including the observation for any signs or symptoms of abuse and to confirm the safety and safe environment of the residents. Any problems identified are addressed immediately and a written report is provided to the DON of every round for review. The DON reports any problems to the Administrator and the Administrator reports findings to the Corporate Compliance Nurse daily, including weekends and holidays. The Administrator or DON also report Any adverse findings of to the facility Quality Assurance Committee M-F x 30 days, then monthly x 12 months, and called meetings as necessary on weekends or holidays. The Committee consists of the Administrator, DON, Administrative Nurses, Social Services Director, Dietary Director or Assistant, Activities Director, Maintenance Director, Human Resources Director, and the Environmental Services Director and Medical Director. *(See Attachment #3, NASR Rounds and Charge Nurse Rounds Form, Attachment #6.)*

## F223 Continued

3g

Monitoring of incident reports continues 7 days per week x 30 days by Administrative Nurses (DON or Administrative LPN's) and then M-F in daily staff meetings with weekend or holiday reports reviewed on the next business day for 7 days per week review by Administrative Nurses that includes the DON, and Administrative LPN's. Any problems identified are reported immediately to the Administrator and the Corporate Compliance Nurse. The Administrator also reports findings to the facility Quality Assurance Committee monthly ongoing and called meetings as necessary.

The CQI Committee consists of the Administrator, DON, Administrative Nurses, Social Services Director, Dietary Director, Activities Director, Maintenance Director, Human Resources Director, the Environmental Services Director and the Medical Director.

Care plans are reviewed and updated by the Charge Nurse or appropriate discipline as needed and as scheduled. Care plan changes are monitored daily by the DON or Administrative Nurse x 30 days, and then daily, Monday thru Friday, in staff meetings. *(See Daily Report Form (QA), Attachment # 7.)*

**F223 Continued**

3h

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director and the Compliance and/or Charge Nurse M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 day per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director, Charge and/or Compliance Nurses. *(See BOP Monitor sheets, Attachment #1.)*

Corporate Compliance Nurse monitors the Administrator daily x 30 days and then weekly by required written report to include any alleged violations involving mistreatment, neglect or abuse of residents. Any investigations initiated are reviewed to assure that adequate investigating and reporting has taken place. Verbal communication and/or on-site visits continue daily for a 30 day period and then weekly ongoing.

Social Services Director is scheduled Monday through Friday (M-F) and is being monitored daily thru the facility Quality Assurance Review M-F x 30 days and by the Administrator including weekends and holidays as issues or concerns are determined.

In addition to daily CQI/QA activity for 30 days, in daily staff meeting, the CQI Committee reviews all monitoring monthly ongoing including monitoring for abuse.

**5. Date Corrected:****4-11-12**

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
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{F 225}	<p>Continued From page 3</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to implementing facility's policy and procedure on investigation and reporting of alleged resident to resident abuse.</p>	{F 225}	<p><b>F225</b> <b>Residents #1, #4, #5, #6 &amp; #7</b></p> <p><b>1. Corrective Action:</b></p> <p>Any allegation of abuse received from persons inside the facility or from an outside provider are investigated upon initial report.</p> <p>Education and conference was conducted by Administrator and DON on March 27, 2012, with the outside provider referred to in the 2567 regarding the reporting of incidents in this facility and supervision of residents. Person voiced understanding of how to report.</p> <p>Administrator confirmed with staff consultation (DON, Administrative Nurses and Corporate Compliance Nurse) and record review that any corrective action needed for these identified residents was completed and documented by March 29, 2012;</p>		

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{F 225}	<p>Continued From page 4</p> <p>However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and had not had an opportunity to develop and implement a Plan of Correction (POC), related to the investigation and reporting of resident to resident abuse.</p> <p>The findings include:</p> <p>Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed the Corporate Compliance Nurse trained the Administrator, on 03/21/12, that all alleged violations involving mistreatment, neglect or abuse must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violation are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. It is the responsibility of the Administrator to ensure sufficient and adequate investigation and reporting are accomplished. It was determined all residents were potentially at risk for abuse and all residents were observed and interviewed by licensed nursing staff related to abuse. A system of reporting had been established beginning with nurse aide hourly rounds and charge nurse compliance rounds completed twice each shift. The nurse aide hourly reports were passed to the charge nurse for review at the end of each shift, with the exception of any problems which were reported immediately to the charge nurse. The information gained during the charge nurse compliance rounds was given to the DON during the week days and to the Administrative nurse on the weekend days. Any problems were</p>	{F 225}	<p>Resident #1 was placed on one to one supervision on 2-19-12 while at the facility until transferred for mental health treatment in accordance with the facility's abuse policy. At the time of the psychiatric hospital discharge, the resident was no longer exhibiting agitation or aggression per the discharge summary. One to one supervision was again initiated by DON on March 16, 2012, in an effort to assure that no resident would be affected by Resident #1.</p> <p>Resident #1 was assessed by the MDS Coordinator and Social Services Director, utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities.</p> <p>Residents #4 &amp; 5 were fully assessed by Charge Nurse on February 19, 2012; family and physician notified and care plans up-dated.</p> <p>Resident #6 &amp; #7 were moved to other rooms away from resident #1, 2-21-12 and 12-7-11, by Social Services Director and DON.</p> <p>Care plans were reviewed and revised for Residents #1, 4, 5, 6 and 7 by the Social</p>	

## F225 Continued

5a

Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows:

**Res #1** Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident

**Res #4** Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard

**Res #5** Diversional activities revised to include coloring, puzzles, and TV

**Res #6** Revised care plan on making false accusations, revised potential for verbal abuse to include argumentative, interventions revised to include behavior activity box, and conversation

**Res #7** Changed diversional activities to conversing, TV, games and personalized activity box

MDS Coordinator reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink, toilet, reposition, verbal cues,

**F225 Continued**

5b

redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)*

**2. ID of Other Residents:**

All residents could be considered potentially at risk however, all residents were assessed by Licensed Nursing Staff on 3-21-12 utilizing observation and interview with no other residents identified as being mistreated, abused, or any resident showing signs of distress. *(See Residents at Risk for Abuse Assessment form, Attachment #5.)*

**3. Preventative Measures:**

Inservice was held on March 21, 2012, for all Administrative Nurses (including two Charge Nurses), Social Services Director, Administrator, and other Supervisory and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate

**F225 Continued**

5c

Compliance Nurse and the Administrator. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report.

ALL staff inserviced by March 22, 2012 on the Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, with the initial inservice provided by the Corporate Compliance Nurse and any remaining persons were inserviced by the Administrator, DON, or Administrative Staff (Administrative Nurse, RN Charge Nurse, Social Services Director) on an individual basis prior to their next shift. All new hires receive same training in initial Corporate orientation with Corporate Nurse Trainer. *(See Abuse Policy and Inservice Record, Attachment #2 thru 2h)*

Nurse aide rounds are in place every hour and documentation initiated by DON on March 21, 2012 to view residents frequently, know their whereabouts, assess the environment for accident hazards and maintaining a safe environment. This includes observing for signs of abuse or potential abuse situations. Charge Nurses were inserviced

F225 Continued

5d

by DON on NASR rounds' documentation on March 21, 2012. All NASR's and NA's educated on the documentation requirements for Nurse Aide Rounds at the beginning of each shift by their Charge Nurse. *(See NASR documentation forms and Inservice Record, Attachment #3 thru 3e)*

Corporate Compliance Nurse trained Administrator March 21, 2012, that all alleged violations involving mistreatment, neglect or abuse must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting.

Corporate Compliance Nurse trained Administrator regarding residents' right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. There must be evidence that residents are protected from abuse and all alleged violations are thoroughly investigated and the facility must prevent potential abuse verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion) of any resident. *(See*

F225 Continued

5e

***Corporate Compliance Nurse Record of  
Inservice Training for ADM  
Documentation Form, Attachment #4.)***

Inservice for all Nursing Staff on March 28, 2012 provided by MDS Coordinator, Compliance Nurse and DON regarding implementation of suggestions and interventions to be utilized through the Behavior Observation Program to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment when behaviors are exhibited by residents. If unsuccessful, Charge Nurse will be notified to assess for 1:1 supervision. ***(See Inservice Training Record r/t Behavior Management, Attachment # 4a)***

ALL staff inserviced on Behavior Observation and Suggested Interventions by DON, Administrative Nurse, and MDS Coordinator on March 29, 2012. Any staff members not in attendance inserviced by Administrative Staff (Administrator, DON, Administrative Nurse, or RN Charge Nurse,) on an individual basis prior to their next shift. All new hires receive same training in initial orientation by Corporate Nurse Trainer. All staff were made aware in March 29, 2012, training of the immediate jeopardy concerns cited by the OIG on

F225 Continued

5f

March 21, 2012. *(See Inservice Training Record r/t Behavior Management, Attachment # 4b thru 4m)*

#### 4. Monitoring

Nurse aide rounds are in place every hour and documentation initiated on March 21, 2012 to view residents frequently, know their whereabouts, assess the environment for accident hazards and maintaining a safe environment. This includes observing for signs of abuse or potential abusive situations. Charge Nurses were inserviced on NASR rounds' documentation on March 21, 2012, by the DON. All NASR's and NA's educated on the documentation requirements at the beginning of each shift by their Charge Nurse. Any issues are corrected and reported to the Charge Nurse immediately. The NASR documents are given to Charge Nurse for review at the end of each shift. The Charge Nurse reports information from the rounds in their report to the DON or

## F225 Continued

5g

Administrative Nurse daily including weekends. The DON reports any problems to the Administrator and the Administrator reports findings to the Corporate Compliance Nurse daily, including weekends and holidays x 30 days and then weekly.

*(See Attachment #3, NASR Rounds and Charge Nurse Rounds Form, Attachment #6.)*

Compliance rounds are completed by Charge Nurses two times per shift including the observation for any signs or symptoms of abuse and to confirm the safety and safe environment of the residents. Any problems identified are addressed immediately and a written report is provided to the DON of every round for review. The DON reports any problems to the Administrator and the Administrator reports findings to the Corporate Compliance Nurse daily, including weekends and holidays x 30 days and then weekly. The Administrator or DON also report findings to the facility Continuous Quality Improvement (CQI) Committee M-F and called meetings as necessary on weekends or holidays. The Committee consists of the Administrator, DON, Administrative Nurses, Social Services Director, Medical Director, Dietary Director or Assistant, Activities Director, Maintenance Director,

**F225 Continued**

5h

Human Resources Director, and the Environmental Services Director.  
*(See Attachment #3, NASR Rounds and Charge Nurse Rounds Form, Attachment #6.)*

Monitoring of incident reports continues 7 days per week x 30 days by Administrative Nurses (DON or Administrative LPN's) and then M-F in daily staff meetings with weekend or holiday reports reviewed on the next business day for 7 days per week review by Administrative Nurses that includes the DON, and Administrative LPN's. Any problems identified are reported immediately to the Administrator and the Corporate Compliance Nurse. The Administrator also reports findings to the facility Continuous Quality Improvement (CQI) Committee monthly ongoing and called meetings as necessary.

Care plans are reviewed and updated by the Charge Nurse or appropriate discipline as needed and as scheduled. Care plan changes are

**F225 Continued**

5i

monitored daily by the DON or Administrative Nurse. *(See Daily Report Form (QA), Attachment # 7.)*

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director and/or the Charge Nurse x 30 days and then M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 day per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. *(See BOP Monitor sheets, Attachment #1.)*

Corporate Compliance Nurse monitors the Administrator daily x 30 days and then weekly by required written report to include any alleged violations involving mistreatment, neglect or abuse of residents. Any investigations initiated are reviewed to assure that adequate investigating and reporting has taken place. Verbal communication and/or on-site visits continue daily for a 30 day period and then weekly ongoing.

**F225 Continued**

5j

Social Services Director is scheduled Monday through Friday (M-F) and is being monitored for 30 days thru the facility Continuous Quality Improvement (CQI) Review M-F and by the Administrator as well on weekends and holidays as issues or concerns are determined.

In addition to daily CQI/QA activity in daily staff meeting, the CQI Committee reviews all monitoring monthly ongoing including monitoring for abuse.

**5. Date Corrected:**

**4-11-12**

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

PRINTED: 05/21/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>186263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>04/10/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>DAWSON POINTE, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>213 WATER STREET DAWSON SPRINGS, KY 42408</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
{F 225}	Continued From page 5 immediately reported to the DON, the Administrator, and the Corporate Compliance Nurse. The Corporate Compliance Nurse was receiving a written report from the Administrator on a daily basis to monitor alleged violations related to abuse, neglect, or mistreatment of resident.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).	{F 225}	<b>F226</b> <b>Residents #1, #4, #5, #6 &amp; #7</b>  <b>1. Corrective Action:</b>  Administrator confirmed with staff consultation (DON, Administrative Nurses and Corporate Compliance Nurse) and record review that any corrective action needed for these identified residents was completed and documented by March 29, 2012:  <b>Resident #1</b> was placed on one to one supervision on 2-19-12 while at the facility until transferred for mental health treatment in accordance with the facility's abuse policy. At the time of the psychiatric hospital discharge, the resident was no longer exhibiting agitation or aggression per the discharge summary. One to one supervision was again initiated by DON on March 16, 2012, in an effort to assure that no resident would be affected by Resident #1.  <b>Resident #1</b> was assessed by the MDS Coordinator and Social Services Director, utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities.		
{F 226} SS=D	<b>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</b>  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to implementing the facility's policy and procedure on resident to resident abuse. However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of	{F 226}			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
(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 226}	<p>Continued From page 6</p> <p>Information and had not had an opportunity to develop and implement a Plan of Correction (POC), related to the implementation of the facility's policy and procedure which addressed abuse prevention, identification, intervention, and reporting.</p> <p>The findings include:</p> <p>Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed training by the Corporate Compliance Nurse identified the Administrator as the person responsible to ensure there is sufficient and adequate investigation and reporting of all incidents and allegations related to the facility's abuse policy and procedure. In-services covering the facility's Abuse, Neglect, and Exploitation policy and procedure were provided for all administrative personnel and facility staff to include detailed information on appropriate interventions, reporting allegations, reorganization of abuse, and the investigation required. A system has been established involving the Corporate Compliance Nurse receiving a written report from the Administrator on a daily basis to monitor alleged violations related to abuse, neglect, or mistreatment of resident.</p> <p>Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).</p>	{F 226}	<p>Residents #4 &amp; 5 were fully assessed by Charge Nurse on February 19, 2012; family and physician notified and care plans updated.</p> <p>Resident #6 &amp; #7 were moved to other rooms away from resident #1, 2-21-12 and 12-7-11, by Social Services Director and DON.</p> <p>Care plans were reviewed and revised for Residents #1, 4, 5, 6 and 7 by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows: Res #1 Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident Res #4 Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard</p>		

F226 Continued

7a

**Res #5** Diversional activities revised to include coloring, puzzles, and TV

**Res #6** Revised care plan on making false accusations, revised verbal abusive to include argumentative, interventions revised to include behavior activity box, and conversation

**Res #7** Changed diversional activities to conversing, TV, games and personalized activity box

MDS Coordinator reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)*

## 2. ID of Other Residents:

All residents could be considered potentially at risk however, all residents were assessed by Licensed Nursing Staff on 3-21-12 utilizing observation and interview with no other residents identified as being

F226 Continued

7b

mistreated, abused, or any resident showing signs of distress. (*See Residents at Risk for Abuse Assessment form, Attachment #5.*)

### 3. Preventative Measures:

Inservice was held on March 21, 2012, for all Administrative Nurses (including two Charge Nurses), Social Services Director, Administrator, and other Supervisory and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse and the Administrator. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse and how to identify events and initiate an investigation including who, when and how to report.

ALL staff inserviced by March 22, 2012 on the Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, with the initial inservice provided by the Corporate Compliance Nurse and any remaining persons were inserviced by the Administrator, DON, or

F226 Continued

7c

Administrative Staff (Administrative Nurse, RN Charge Nurse, Social Services Director) on an individual basis prior to their next shift. All new hires receive same training in initial Corporate orientation with Corporate Nurse Trainer. *(See Abuse Policy and Inservice Record, Attachment #2 thru 2h)*

Nurse aide rounds are in place every hour and documentation initiated by DON on March 21, 2012 to view residents frequently, know their whereabouts, assess the environment for accident hazards and maintaining a safe environment. This includes observing for signs of abuse or potential abuse situations. Charge Nurses were inserviced by DON on NASR rounds' documentation on March 21, 2012. All NASR's and NA's educated on the documentation requirements for Nurse Aide Rounds at the beginning of each shift by their Charge Nurse. *(See NASR documentation forms and Inservice Record, Attachment #3 thru 3e)*

Corporate Compliance Nurse trained Administrator March 21, 2012, that all alleged violations involving mistreatment, neglect or abuse must be reported to other officials such as the DCBS and OIG. There must be evidence that all alleged violations are thoroughly investigated

F226 Continued

7d

and must prevent further potential abuse while the investigation is in progress. The Administrator is to ensure there is sufficient and adequate investigation and reporting.

Corporate Compliance Nurse trained Administrator regarding residents' right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. There must be evidence that residents are protected from abuse and all alleged violations are thoroughly investigated and the facility must prevent potential abuse verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion) of any resident. *(See Corporate Compliance Nurse Record of Inservice Training for ADM Documentation Form, Attachment #4.)*

Inservice for all Nursing Staff on March 28, 2012 provided by MDS Coordinator, Compliance Nurse and DON regarding implementation of suggestions and interventions to be utilized through the Behavior Observation Program to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment when behaviors are exhibited by residents. If unsuccessful, Charge Nurse will be notified to assess for 1:1 supervision. *(See Inservice Training Record r/t Behavior Management, Attachment # 4a)*

ALL staff inserviced on Behavior Observation and Suggested Interventions

F226 Continued

7e

by DON, Administrative Nurse, and MDS Coordinator on March 29, 2012. Any staff members not in attendance inserviced by Administrative Staff (Administrator, DON, Administrative Nurse, or RN Charge Nurse,) on an individual basis prior to their next shift. All new hires receive same training in initial orientation by Corporate Nurse Trainer. All staff were made aware in March 29, 2012, training of the immediate jeopardy concerns cited by the OIG on March 21, 2012. *(See Inservice Training Record r/t Behavior Management, Attachment # 4b thru 4m)*

#### 4. Monitoring

Nurse aide rounds are in place every hour and documentation initiated on March 21, 2012 to view residents frequently, know their whereabouts, assess the environment for accident hazards and maintaining a safe environment. This includes observing for signs of abuse or potential abusive situations. Charge Nurses were inserviced on NASR rounds' documentation on March 21, 2012, by the DON. All NASR's and NA's educated on the documentation requirements at the beginning of each shift by their Charge Nurse. Any issues are corrected and reported to the Charge Nurse immediately. The NASR documents are given to Charge Nurse for review at the end of each shift. The Charge

F226 Continued

7f

Nurse reports information from the rounds in their report to the DON or Administrative Nurse daily including weekends. The DON reports any problems to the Administrator and the Administrator reports findings to the Corporate Compliance Nurse daily, including weekends and holidays. *(See Attachment #3, NASR Rounds and Charge Nurse Rounds Form, Attachment #6.)*

Compliance rounds are completed by Charge Nurses two times per shift including the observation for any signs or symptoms of abuse and to confirm the safety and safe environment of the residents. Any problems identified are addressed immediately and a written report is provided to the DON of every round for review. The DON reports any problems to the Administrator and the Administrator reports findings to the Corporate Compliance Nurse daily, including weekends and holidays. The Administrator or DON also report findings to the facility's Continuous Quality Improvement (CQI) Committee M-F and called meetings as necessary on weekends or holidays.

The CQI Committee consists of the Administrator, DON, Administrative Nurses, Social Services Director, Medical Director, Dietary Director or Assistant, Activities Director, Maintenance Director,

F226 Continued

7g

Human Resources Director, and the Environmental Services Director.  
*(See Attachment #3, NASR Rounds and Charge Nurse Rounds Form, Attachment #6.)*

Monitoring of incident reports continues 7 days per week x 30 days by Administrative Nurses (DON or Administrative LPN's) and then M-F in daily staff meetings with weekend or holiday reports reviewed on the next business day for 7 days per week review by Administrative Nurses that includes the DON, and Administrative LPN's. Any problems identified are reported immediately to the Administrator and the Corporate Compliance Nurse. The Administrator also reports findings to the facility's Continuous Quality Improvement Committee monthly ongoing and called meetings as necessary.

Care plans are reviewed and updated by the Charge Nurse or appropriate discipline as needed and as scheduled. Care plan changes are monitored daily x 30 days, then M-F with weekend and holidays reviewed on next business day by the DON or Administrative Nurse. *(See Daily Report Form (QA), Attachment # 7.)*

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director

F226 Continued

7h

and/or the Charge Nurse x 30 days and then M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 day per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. *(See BOP Monitor sheets, Attachment #1.)*

Corporate Compliance Nurse monitors the Administrator daily x 30 days and then weekly by required written report to include any alleged violations involving mistreatment, neglect or abuse of residents. Any investigations initiated are reviewed to assure that adequate investigating and reporting has taken place. Verbal communication and/or on-site visits continue daily for a 30 day period and then weekly ongoing.

Social Services Director is scheduled Monday through Friday (M-F) and is being monitored daily thru the facility Continuous Quality Improvement review M-F and by the Administrator as well on weekends and holidays as issues or concerns are determined.

**F226 Continued**

7i

In addition to daily CQI/QA activity in daily staff meeting, the CQI Committee reviews all monitoring monthly ongoing including monitoring for abuse.

5. **Date Corrected:**

**4-11-12**

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
(X4) IO 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 250} SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to medically related Social Services to address resident behaviors that could lead to resident to resident abuse. However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and had not had an opportunity to develop and implement a Plan of Correction (POC), related to medically related Social Services involvement with residents with behaviors that could lead to resident to resident abuse.</p> <p>The findings include:</p> <p>Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed the Social Services Director has been provided training and updated tools to include a guide for care planning titled "The New Care Plan Answer Book for Activity, Psychosocial and Social Work Programs". The Social Services Director has worked in conjunction with the Minimum Data Set</p>	{F 260}	<p>F250 Residents #1, #4, #5, #6, and #7</p> <p>1. Corrective Action:</p> <p>Resident #1 was assessed by the MDS Coordinator and Social Services Director on March 29, 2012, , utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities.</p> <p>Care plans were reviewed and revised for Residents # 1, 4, 5, 6 and 7 by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows: Res #1 Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident Res #4 Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard Res #5 Diversional activities revised to include coloring, puzzles, and TV Res #6 Revised care plan on making false accusations, revised potential for verbal abuse to include argumentative, interventions revised to include behavior activity box, and conversation</p>	

F250 Continued

8a

**Res #7** Changed diversional activities to conversing, TV, games and personalized activity box

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director and the Compliance and/or Charge Nurse M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 day per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. *(See BOP Monitor sheets, Attachment #1.)*

Inservice was held on March 21, 2012, for all Administrative Nurses (including two Charge Nurses), Social Services Director, Administrator, and other Supervisory and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse and the Administrator. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse

**F250 Continued**

**8b**

and how to identify events and initiate an investigation including who, when and how to report.

By compliance date, supplemental training related to behaviors and continuous quality improvement scheduled ongoing with professional healthcare consultant group for the Social Services Director (SSD), along with licensed staff and management.

This is a nationally recognized group specializing in the provision of long term care consulting and education.

ALL staff inserviced on Behavior Observation and Suggested Interventions by DON, Administrative Nurse, and MDS Coordinator on March 29, 2012. Any staff members not in attendance inserviced by Administrative Staff (Administrator, DON, Administrative Nurse, or RN Charge Nurse,) on an individual basis prior to their next shift.

F250 Continued

8c

All new hires receive same training in initial orientation by Corporate Nurse Trainer. *(See Inservice Training Record r/t Behavior Management, Attachment # 4b thru 4m)*

MDS Coordinator reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)*

**2. ID of Other Residents at Risk:**

All residents could be considered potentially at risk however, all residents were assessed by Licensed Nursing Staff on 3-21-12 utilizing observation and interview with no other residents identified as being mistreated, abused, or any resident showing signs of distress. *(See Residents at Risk for Abuse Assessment form, Attachment #5.)*

F250 Continued

8d

**3. Preventive Measures:**

Behavior Observation Program sheets are reviewed daily by the Social Services Director and the Charge Nurse M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 day per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director, MDS Coordinator or the Charge Nurses.  
*(See BOP Monitor sheets, Attachment #1.)*

Inservice was held on March 21, 2012, for all Administrative Nurses (including two Charge Nurses), Social Services Director, Administrator, and other Supervisory and Department Leaders. The Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, was used as a guide along with the regulation related to abuse and neglect and was presented to the group in detail by the Corporate Compliance Nurse and the Administrator. Information in the training included appropriate interventions, how staff should report allegations, how to recognize abuse, what constitutes abuse

F250 Continued

8e

and how to identify events and initiate an investigation including who, when and how to report.

By compliance date, supplemental training related to behaviors and continuous quality improvement scheduled ongoing with professional healthcare consultant group for the Social Services Director (SSD), along with licensed staff and management.

This is a nationally recognized group specializing in the provision of long term care consulting and education.

ALL staff inserviced on Behavior Observation and Suggested Interventions by DON, Administrative Nurse, and MDS Coordinator on March 29, 2012.  
Any staff members not in attendance

F250 Continued

8f

inserviced by Administrative Staff (Administrator, DON, Administrative Nurse, or RN Charge Nurse,) on an individual basis prior to their next shift. All new hires receive same training in initial orientation by Corporate Nurse Trainer. *(See Inservice Training Record r/t Behavior Management, Attachment # 4b thru 4m)*

Resident #1 was assessed by the MDS Coordinator and Social Services Director, on March 29, 2012, utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities.

Care plans were reviewed and revised for Residents # 1, 4, 5, 6 and 7 by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows:

#1 Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident

#4 Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard

#5 Diversional activities revised to include coloring, puzzles, and TV

#6 Revised care plan on making false accusations, revised potential for verbal abuse to include argumentative, interventions revised to include behavior activity box, and conversation

#7 Changed diversional activities to conversing, TV, games and personalized activity box

MDS Coordinator reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)*

#### 4. Monitor

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director and/or the Charge Nurse M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 day per week review to determine

Dawson Pointe, LLC  
Survey Completed 04/10/2012

ID#185263

**F250 Continued**

**8h**

if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. *(See BOP Monitor sheets, Attachment #1.)*

Behavior Observation Program (BOP) Review Tool will be presented at the Monthly to the facility CQI Committee. Any issues addressed

**5. Date Corrected:**

**4-11-12**

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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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 260}	Continued From page 8 (MDS) Coordinator and DON to review and rewrite care plans approaches and interventions to address behaviors. A system has been established to monitor the Behavior Observation Program (BOP) sheets on a daily basis for the effectiveness of behavioral interventions and the need for care plan revision. The Social Services Director is monitored daily by the Quality Assurance Review team (Monday through Friday) and the Administrator (weekends and holidays) as issues and/or concerns are revealed.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).	{F 250}	F280 Residents #1, #2, #3, #4, #5, #6 & #7  1. Corrective Actions:  Care plans were reviewed and revised for Residents # 1, 4, 5, 6 & #7, by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows: Res #1 Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident Res #4 Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard Res #5 Diversional activities revised to include coloring, puzzles, and TV Res #6 Revised care plan on making false accusations, revised for potential verbal abuse to include argumentative, interventions revised to include behavior activity box, and conversation Res #7 Changed diversional activities to conversing, TV, games and personalized activity box	
{F 280} SS=E	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	{F 280}		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
(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 280}	Continued From page 9 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 Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to revision of care plans of residents who were identified at risk for resident to resident abuse and on specialty diets. However, non-compliance continued to exist at a S/S of a "E" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and had not had an opportunity to develop and implement a Plan of Correction (POC), related to the revision of care plans of residents who were identified at risk for resident to resident abuse and on specialty diets.  The findings include:  Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed the care plans for residents #1, #4, #5, #6, and #7 were revised on 03/29/12 by the Social Services Director and the Minimum Data Set (MDS) Coordinator to include interventions and approaches specific to each resident. In relation to the new system of daily monitoring incident reports, the resident care plans were reviewed	{F 280}	<b>280 Continued</b>  <b>Res #2 and Res #3:</b> A nutritional review of Res #2 and Res #3, along with other residents, was conducted by the Registered Dietitian and the Assistant Dietary Manger on March 29, 2012. Diet orders and dietary/nutrition care plans were reviewed for any changes needed. Physician orders compared to tray cards and tray cards updated on March 29, 2012, by the RD.  <b>2. ID of Others at Risk:</b>  All residents considered to be at risk for abuse or incidental, occasional choking. All residents assessed for abuse by Licensed Nursing Staff utilizing observation and interview. (See <i>Residents at Risk for Abuse Assessment form</i> ). All residents assessed for choking by Licensed Nursing Staff utilizing observation and interview. (See <i>Residents at Risk for Choking Assessment form, exhibit 5a</i> ).  <b>3. Prevention:</b>  MDS Coordinator reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and	

F280 Continued

10a

other staff members to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)*

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director and/or the Charge Nurse x 30 days and then M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 days per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. *(See BOP Monitor sheets, Attachment #1.)*  
Meal tray monitor continues daily at mealtime by trained staff.

280 Continued

10b

Any issues related to meals or behaviors are referred to the Charge Nurse and then daily to the Continuous Quality Improvement (CQI) meeting by licensed staff or DON who receives information from Charge Nurse. The CQI team utilizes Plan, Do, Study and Act (PDSA) as the model or system for the review process Monday --Friday with incidents from the weekend reviewed on Monday or a called meeting as deemed necessary by Administrator or DON for any incident including but not limited to choking or abuse.

By compliance date, supplemental training related to behaviors and continuous quality improvement scheduled ongoing with professional healthcare consultant group for the Social Services Director (SSD), along with licensed staff and management. This is a nationally recognized group specializing in the provision of long term care consulting and education.

**4. Monitoring**

Care plans are reviewed and updated by the Charge Nurse or appropriate discipline as needed and as scheduled. Care plan changes are monitored M-F with weekends and holidays monitored on the next business day for a daily review by the DON or Administrative Nurse. *(See Daily Report Form (QA), Attachment # 7.)*

Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. BOP sheets reviewed daily by the Social Services Director and/or the

Charge Nurse to determine if interventions have been successful and if care plans need to be reviewed and revised. *(See BOP Monitor sheets, Attachment #1.)*

Social Services Director is scheduled Monday through Friday (M-F) and is being monitored daily x 30 days thru the facility's Continuous Quality Improvement review M-F and by the Administrator as well on weekends and holidays as issues or concerns are determined.

Care Plan Monitoring Tool will be presented in the monthly CQI meeting for review x 3 months and then quarterly.

5. Date Corrected:

4-11-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
(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 280}	Continued From page 10 and updated accordingly by the charge nurse of other appropriate discipline. In addition, care plan changes were monitored daily by the DON or administrative nurse in charge. Care plans were also reviewed and revised in regard to information gathered from the Behavior Observation Program (BOP) sheets on a daily basis.  All resident dietary care plans were reviewed and revised by the Registered Dietitian (RD) or Certified Nutritionist (CN) on 03/29/12. A comparison between the physician's orders and the dietary tray cards were completed with updates made. A daily review with updates as needed was performed by the Registered Dietitian and/or the Certified Nutritionist. A system has been established for charge nurses to report, on a daily basis, any dietary care plan changes not made by the RD or CN to the DON who would then report the changes to the RD or CN for review. A daily report was made to the Corporate Compliance Nurse detailing dietary care plans and diet orders.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).	{F 280}	<b>F282</b> Residents #1, #2, #3, #4, #5, #6 & #7  Care plans were reviewed and revised for Residents # 1, 4, 5, 6 & #7, by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows: <b>Res #1</b> Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident <b>Res #4</b> Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard <b>Res #5</b> Diversional activities revised to include coloring, puzzles, and TV <b>Res #6</b> Revised care plan on making false accusations, revised for potential verbal abuse to include argumentative, interventions revised to include behavior activity box, and conversation <b>Res #7</b> Changed diversional activities to conversing, TV, games and personalized activity box	
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility	{F 282}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 282}	Continued From page 11 must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to implementation of interventions related to resident to resident abuse and specially diets. However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and had not had an opportunity to develop and implement a Plan of Correction (POC), related to the implementation of interventions related to resident to resident abuse and specially diets.  The findings include:  Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed the Minimum Data Set (MDS) Coordinator reviewed and revised the Behavior Observation Program (BOP) sheets and the nurse aide care plans for all residents on 03/29/12. The revisions included interventions specific to each resident with a sticker placed on the BOP sheet as a reminder of the suggested interventions. Further, training was completed on 03/29/12, for all nursing staff and new hires during orientation regarding appropriate documentation on the Behavior Management Log to indicate resident responses	{F 282}	<b>F282 Continued</b>  <b>Res #2 and Res #3:</b> A nutritional review of Res #2 and Res #3, along with other residents, was conducted by the Registered Dietitian and the Assistant Dietary Manger on March 29, 2012. Diet orders and dietary/nutrition care plans were reviewed for any changes needed. Physician orders compared to tray cards and tray cards updated on March 29, 2012, by the RD.  On March 17, 2012, resident meal/tray direct observation was initiated for all residents. The observation is completed 3 meals per day, 7 days per week, for a period of 30 days at the point of tray assembly and the point of tray service by a Licensed Nurse, RD or Certified Nutritionist. Observation records are provided to the DON and the Administrator daily. Snacks are monitored and served by the Certified Medication Aides with documentation provided to the DON daily.		

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 282}	<p>Continued From page 12 to interventions attempted. In an instance of unsuccessful attempts, the nursing staff are to notify the charge nurse for assessment of the need for 1:1 supervision.</p> <p>Resident #2 and Resident #3 were placed on one to one supervision for all meals and snacks. All resident dietary care plans were reviewed and revised by the Registered Dietitian (RD) or Certified Nutritionist (CN) on 03/29/12. A comparison between the physician's orders and the dietary tray cards were completed with updates made. A daily review with updates as needed was performed by the Registered Dietitian and/or the Certified Nutritionist. Resident meal/tray observations were initiated on 03/21/12 for all resident diets at the point of tray origin for all meals. Supervised dining was initiated on 03/17/12 for all residents requiring assistance of feeding. An additional dining room was set up on 03/16/12 for all resident who required assistance with feeding. Those residents identified for high risk were supervised one to one with feeding. All dietary staff and staff members were educated on Modified Textured Diets on 03/28/12 and 03/29/12. A pre-test and post-test was administered. Modified texture diet trays are checked by a licensed staff member prior to serving to ensure the residents are receiving the appropriate diet. This will continue for 30 days and reports are communicated to the DON for review and then the Administrator by the DON. A report is then communicated to the Corporate Compliance Nurse daily by the Administrator. Any problems identified were corrected immediately. A system has been established for charge nurses to report, on a daily basis, any dietary care plan changes not made by</p>	{F 282}	<p><b>F282 Continued</b></p> <p>On March 17, 2012, supervised dining was initiated for all residents requiring assistance with feeding. An additional dining area was set up in the multipurpose room of the facility to provide assisted dining along with independent and social dining in open areas with increased supervision. Those identified at high risk will be directly supervised by staff during meals.</p> <p><b>2. ID of Other Residents at Risk:</b></p> <p>All residents could be considered potentially at risk for abuse or choking however, all residents were assessed for abuse or choking by Licensed Nursing Staff on March 21, 2012, utilizing observation and interview. <i>(See Residents at Risk for Choking Assessment form, exhibit 5a and Residents at Risk for Abuse Assessment form, Attachment #5).</i></p> <p><b>3. Prevention Measures:</b></p> <p>MDS Coordinator reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and</p>	

F282 Continued

13a

other staff members to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)*

Additional training scheduled as available with Pat Boyer and Associates for the Social Services Director (SSD), licensed staff and management. This is a nationally recognized group specializing in the provision of long term care consulting and education. The Boyer training will address:

1. Behavior management by the SSD and other staff of residents with psychiatric diagnoses and aggressive behaviors.
2. SSD and other staff implementing interventions to protect residents from harm
3. The effective use of care plans and interventions by the SSD and other staff
4. Patient counseling, remedies by SSD

**F282 Continued**

**13b**

5. SSD reporting and investigating complaints
6. Physician contact when needed by SSD and licensed staff
7. Resident assessment by the SSD and licensed staff
8. Staff training by the SSD

On March 17, 2012, resident meal/tray direct observation was initiated for all residents. The observation is being completed 3 meals per day, 7 days per week, for a period of 30 days at the point of tray assembly and the point of tray service by a Licensed Nurse, RD or Certified Nutritionist. Observation records are provided to the DON and the Administrator daily.

Snacks are monitored and served by the Certified Medication Aides with documentation provided to the DON daily.

F282 Continued

13c

On March 17, 2012, supervised dining was initiated for all residents requiring assistance with feeding. An additional dining area was set up in the multipurpose room of the facility to provide assisted dining along with independent and social dining in open areas with increased supervision. Those identified at high risk will be directly supervised by staff during meals.

**4. Monitor:**

Care plans are reviewed and updated by the Charge Nurse or appropriate discipline as needed and as scheduled. Care plan changes are monitored M-F with weekends and holidays monitored on the next business day for a daily review by the DON or Administrative Nurse. *(See Daily Report Form (QA), Attachment # 7.)*

Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. BOP sheets reviewed daily by the Social Services Director and/or the

Charge Nurse to determine if interventions have been successful and if care plans need to be reviewed and revised. *(See BOP Monitor sheets, Attachment #1.)*

**F282 Continued**

**13d**

Social Services Director is scheduled Monday through Friday (M-F) and is being monitored daily x 30 days thru the facility's Continuous Quality Improvement review M-F and by the Administrator as well on weekends and holidays as issues or concerns are determined.

Care Plan Monitoring Tool will be presented in the monthly CQI meeting for review x 3 months and then quarterly.

Daily monitoring of trays will continue for a period of 30 days by licensed staff in the kitchen and the point of service. Monitoring will then become the responsibility of trained staff in Nursing and Dietary. Reports are provided by the Licensed Staff to the DON for review and then to the Administrator by the DON. Any problems will be corrected immediately and reported to a Registered Dietitian (RD), the Corporate Compliance Nurse and the Administrator. The Administrator or RD will report findings to the facility's Continuous Quality Improvement Committee utilizing the Dining/Meal Review CQI tool weekly x 3 months, then monthly x 12 months and ongoing.

**5. Date Corrected:**

**4-11-12**

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
(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 282}	Continued From page 13 the RD or CN to the DON who would then report the changes to the RD or CN for review. A daily report was made to the Corporate Compliance Nurse detailing dietary care plans and diet orders. Snacks are reviewed by the Certified Medication Aides (CMA's) and monitored by the CMAs with documentation provided to the DON daily. The DON provides communication to the Administrator daily.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).	{F 282}		
{F 323} SS=E	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 Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) Identified during the abbreviated survey, concluded on 03/22/12, had	{F 323}	<b>F323</b> <b>Residents #1, #2, #3, #4, #5, &amp; #7</b>  <b>I. Corrective action:</b>  <b>Resident #1</b> was assessed by the MDS Coordinator and Social Services Director, utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities on March 29, 2012.  <b>Resident #1</b> placed on one to one supervision March 16, 2012, in order to prevent any abuse to other residents.  Consultant Psychiatrist scheduled to meet with Behavior Committee on a regular basis beginning in the May 2012 meeting.  Care plans were reviewed and revised for <b>Residents # 1, 4, 5, 6 and 7</b> by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows:	

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{F 323}	<p>Continued From page 14</p> <p>been removed related to ensure residents received adequate supervision to prevent resident to resident abuse and ensure residents received the appropriate form of diet according to residents individual needs. However, non-compliance continued to exist at a S/S of a "E" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and the facility had not had an opportunity to develop and implement a Plan of Correction (POC), related to residents receiving adequate supervision to prevent resident to resident abuse and ensuring residents received the appropriate form of diet according to residents individual needs.</p> <p>The findings include:</p> <p>Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed the Minimum Data Set (MDS) Coordinator reviewed and revised the Behavior Observation Program (BOP) sheets and the nurse aide care plans for all residents on 03/29/12. The revisions included interventions specific to each resident with a sticker placed on the BOP sheet as a reminder of the suggested interventions. Further, training was completed on 03/29/12, for all nursing staff and new hires during orientation regarding appropriate documentation on the Behavior Management Log to indicate resident responses to interventions attempted. In an instance of unsuccessful attempts, the nursing staff are to notify the charge nurse for assessment of the need for 1:1 supervision.</p> <p>Resident #2 and Resident #3 were placed on one to one supervision for all meals and snacks. All</p>	{F 323}	<p><b>F323 Continued</b></p> <p><b>Res #1</b> Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident</p> <p><b>Res #4</b> Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard</p> <p><b>Res #5</b> Diversional activities revised to include coloring, puzzles, and TV</p> <p><b>Res #6</b> Revised care plan on making false accusations, revised potential for verbal abuse include argumentative, interventions revised to include behavior activity box, and conversation</p> <p><b>Res #7</b> Changed diversional activities to conversing, TV, games and personalized activity box</p> <p>MDS Coordinator and Social Services Director reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink, toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. <i>(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g)</i></p>		

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{F 323}	<p>Continued From page 15</p> <p>resident dietary care plans were reviewed and revised by the Registered Dietitian (RD) or Certified Nutritionist (CN) on 03/29/12. A comparison between the physician's orders and the dietary tray cards were completed with updates made. A daily review with updates as needed was performed by the Registered Dietitian and/or the Certified Nutritionist. Resident meal/tray observations were initiated on 03/21/12 for all resident diets at the point of tray origin for all meals. Supervised dining was initiated on 03/17/12 for all residents requiring assistance of feeding. An additional dining room was set up on 03/16/12 for all resident who required assistance with feeding. Those residents identified for high risk were supervised one to one with feeding. All dietary staff and staff members were educated on Modified Textured Diets on 03/28/12 and 03/29/12. A pre-test and post-test was administered. Modified texture diet trays are checked by a licensed staff member prior to serving to ensure the residents are receiving the appropriate diet. This will continue for 30 days and reports are communicated to the DON for review and then the Administrator by the DON. A report is then communicated to the Corporate Compliance Nurse daily by the Administrator. Any problems identified were corrected immediately. A system has been established for charge nurses to report, on a daily basis, any dietary care plan changes not made by the RD or CN to the DON who would then report the changes to the RD or CN for review. A daily report was made to the Corporate Compliance Nurse detailing dietary care plans and diet orders. Snacks are reviewed by the Certified Medication Aides (CMA's) and monitored by the CMAs with documentation provided to the DON daily. The</p>	{F 323}	<p><b>F323 Continued</b></p> <p><b>Res #2 and Res #3:</b> A nutritional review of Res #2 and Res #3, along with other residents, was conducted by the Registered Dietitian and the Assistant Dietary Manger on March 29, 2012. Diet orders and dietary/nutrition care plans were reviewed for any changes needed. Physician orders compared to tray cards and tray cards updated on March 29, 2012, by the RD.</p> <p><b>Res #2</b> Place on supervised dining on March 17, 2012</p> <p><b>Res #3</b> Placed on supervised dining on March 17, 2012</p> <p>On March 17, 2012, resident meal/tray direct observation was initiated for all residents. The observation is being completed 3 meals per day, 7 days per week, for a period of 30 days at the point of tray assembly and the point of tray service by a Licensed Nurse, RD or Certified Nutritionist. Observation records are provided to the DON and the Administrator daily. Snacks are monitored and served by the Certified Medication Aides with documentation provided to the DON daily.</p>	
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**F323 Continued**

**16a**

On March 17, 2012, supervised dining was initiated for all residents requiring assistance with feeding. An additional dining area was set up in the multipurpose room of the facility to provide assisted dining along with independent and social dining in open areas with increased supervision. Those identified at high risk will be directly supervised by staff during meals.

Inservice on the supervision of residents to provide protection in the facility after an allegation of abuse was provided for the Administrator on March 21, 2012, by the Corporate Compliance Nurse and then for supervisory staff including Charge Nurses, Administrative Nurses (DON, ADON, Compliance Nurse), and Department Leaders. Supervision of residents for safety after an allegation of abuse as well as the prevention of abuse was presented to the group along with additional training on the facility Abuse Policy by the Corporate Compliance Nurse and the Administrator. Any remaining supervisory persons not in attendance are required to be inserviced on same topic by the Administrator, DON or

F323 Continued

16b

Administrative Nurses (ADON or Compliance Nurse) on an individual basis prior to their next shift.

ALL staff inserviced by March 22, 2012 on the Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, with the initial inservice provided by the Corporate Compliance Nurse and any remaining persons were inserviced by the Administrator, DON, or Administrative Staff (ADON, Compliance Nurse, RN Charge Nurse, Social Services Director) on an individual basis prior to their next shift.

**2. ID of others at risk:**

All residents considered to be at risk for abuse or incidental, occasional choking.

All residents assessed for abuse by Licensed Nursing Staff utilizing observation and interview. (*See Residents at Risk for Abuse Assessment form*).

All residents assessed for choking by Licensed Nursing Staff utilizing observation and interview. (*See Residents at Risk for Choking Assessment form, exhibit 5a*).

**3. Prevention measures:**

Any issues related to meals or behaviors are referred to the Charge Nurse and then daily to the Continuous Quality Improvement (CQI) meeting by licensed staff or DON who receives information from Charge Nurse. The CQI team utilizes Plan, Do, Study and Act (PDSA) as the model or system for the review process Monday -Friday-

F323 Continued

16c

with incidents from the weekend reviewed on Monday or a called meeting as deemed necessary by Administrator or DON for any incident including but not limited to choking or abuse.

Inservice on the supervision of residents to provide protection in the facility after an allegation of abuse or neglect was provided for the Administrator by the Corporate Compliance Nurse on March 21, 2012, and then for supervisory staff including Charge Nurses, Administrative Nurses (DON, ADON, Compliance Nurse), and Department Leaders. Supervision of residents for safety after an allegation of abuse as well as the supervision to assist in the prevention of abuse was presented to the group by the Corporate Compliance Nurse and the Administrator. Any remaining supervisory persons not in attendance is being required to be inserviced on same topic by the Administrator, DON or Administrative Nurses (ADON or Compliance Nurse) on an individual basis prior to their next shift.

ALL staff inserviced by March 22, 2012 on the Abuse, Neglect and Exploitation Policy that includes the seven steps of abuse prevention, with the initial inservice provided by the Corporate Compliance Nurse and any remaining persons were inserviced by the Administrator, DON, or Administrative Staff (ADON, Compliance Nurse, RN Charge Nurse, Social Services Director) on an individual basis prior to their next shift.

F323 Continued

16d

In an effort to reduce risk to residents, the Corporate Compliance Nurse is to be notified of any allegation of abuse within 24 hours of the incident along with proper reporting to DCBS and OIG. All resident incident reports are reviewed in regularly scheduled Morning Staff Meetings M-F. Any incident reports containing allegations of abuse will be forwarded to the Concord Health Systems Corporate Office for review by the Corporate Compliance Nurse to assure that protection of the resident, investigation and reporting have been accomplished correctly.

All Dietary staff were educated by the Registered Dietitian, or Certified Nutritionist, on March 28, 2012 and March 29, 2012, on Modified Texture Diets, with the objective to ensure safe preparation and service of a texture modified diet such as mechanical soft or pureed diet. A Pre-test and Post-test was administered regarding texture modification with all Dietary staff successfully completing the Post-test. Utilizing materials from the American Dietetic Association, the lesson was delivered by lecture, demonstration, and brainstorming activity. Any Dietary staff member not in attendance educated prior to their next shift by the Registered Dietitian or the Certified Nutritionist. (*See Dietary Inservice, Modified Texture Diets, Attachment #10 thru 10d.*)

All staff members were inserviced by the Registered Dietitian on March 29, 2012, on texture modified diets, the requirements and recognition of texture

F323 Continued

16e

modifications in order to assure accuracy of trays being served . Any staff members not in attendance are educated prior to their next shift by the Registered Dietitian, Certified Nutritionist or Licensed Nursing staff.

New hires are trained in the initial orientation by the Corporate Nurse Trainer. *(See Dietary Inservice, Modified Texture Diets, Attachment #10 thru 10d.)*

#### 4. Monitoring:

Daily monitoring of trays continued for 30 days by licensed staff in the kitchen and the point of service and then monitored by trained Nursing and Dietary staff continuing. Reports of any issues are provided by the Licensed Staff and the Dietary Manager to the DON for review and then to the Administrator by the DON. Any problems will be corrected immediately and reported to the Corporate Registered Dietitian, the Corporate Compliance Nurse and the Administrator. The Administrator will report findings to the facility Quality Assurance Committee utilizing the Dining/Meal Review CQI tool weekly x 3 months, then monthly x 12 months and ongoing.

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director and/or the Charge Nurse x 30 days and then M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 days per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. *(See BOP Monitor sheets, Attachment #1.)*

F323 Continued

16f

Any issues related to meals or behaviors are referred to the Charge Nurse and then daily to the Continuous Quality Improvement (CQI) meeting by licensed staff or DON who receives information from Charge Nurse. The CQI team utilizes Plan, Do, Study and Act (PDSA) as the model or system for the review process Monday –Friday with incidents from the weekend reviewed on Monday or a called meeting as deemed necessary by Administrator or DON for any incident including but not limited to choking or abuse.

Daily monitoring of incident reports by Administrative Nurses (DON, Administrative LPN's) that include investigation and supervision information (including incidents of abuse and choking) implemented 7 days per week (M-F and Weekend and holidays reviewed on next business day) for three months. Any problems will be reported immediately to the Corporate Compliance Nurse for action. Information is also reported to the ADM by the DON. The Administrator or DON reports incident tracking to the facility Continuous Quality Improvement Committee M-F and called meetings as necessary on weekends or holidays and in regular monthly meetings. The Committee consists of the Administrator, DON, Administrative Nurses, Social Services Director, Medical Director, Dietary Director, Activities Director, Maintenance Director, Human Resources Director, and the Environmental Services Director.

5. Date Corrected:

4-11-12

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER 8 STREET DAWSON SPRINGS, KY 42408	
(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 323}	Continued From page 16 DON provides communication to the Administrator daily.	{F 323}		
{F 365} SS=D	<p>Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).</p> <p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to ensuring residents received food in a form that met their individual needs. However, non-compliance continued to exist at a S/S of a "D" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and had not had an opportunity to develop and implement a Plan of Correction (POC), related to residents receiving food in a form that meets their individual needs.</p> <p>The findings include:</p>	{F 365}	<p>F365 Resident #2 &amp; #3</p> <p>1. Corrective Action:</p> <p>Res #2 and Res #3: A nutritional review of Res #2 and Res #3, along with other residents, was conducted by the Registered Dietitian and the Assistant Dietary Manger on March 29, 2012. Diet orders and dietary/nutrition care plans were reviewed for any changes needed. Physician orders compared to tray cards and tray cards updated on March 29, 2012, by the RD.</p> <p>The Dietary Staff prepares and serves the trays of identified residents first at every meal. The trays are checked by a licensed staff to ensure the identified residents are receiving the proper diet and also assures that the resident is adequately supervised or fed as appropriate, directly supervised at the point of service.</p>	

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{F 365}	Continued From page 17  Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed all dietary staff were trained on 03/29/12 regarding Modified Texture diets with a pre-test and post-test completed. Additionally, all facility staff were inserviced by the Registered Dietitian, on 03/29/12, on texture modified diets to include the requirements of texture modification and recognition of texture modification. Monitoring of texture modification food trays begins with food preparation and tray checks in the kitchen and is provided currently by the Registered Dietitian (RD) or Certified Nutritionist (CN). With delivery of the trays to the dining areas, the trays are checked by a licensed staff prior to presentation to the residents. Any problems are corrected immediately and reported to the RD, the Administrator, and the Corporate Compliance Nurse. The daily monitoring of trays is scheduled to continue for 30 days by licensed staff in the kitchen and at the point of service. Reports, beginning with the licensed staff, flow to the DON for review, then to the Administrator and finally to the Corporate Compliance Nurse. Currently, the food preparation is being monitored by an experienced Assistant Dietary Manager from a sister facility and the Head Cook in that the Dietary Manager was terminated on 03/29/12. The newly hired dietary staff are being trained by the Assistant Dietary Manager and/or the RD or CN.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be	{F 365}	F365 Continued  On March 17, 2012, resident meal/ tray direct observation was initiated for all residents. The observation is completed 3 meals per day, 7 days per week, for a period of 30 days at the point of tray assembly and the point of tray service by a Licensed Nurse, RD or Certified Nutritionist. Observation records are provided to the DON and the Administrator daily. Snacks are monitored and served by the Certified Medication Aides with documentation provided to the DON daily.  On March 17, 2012, supervised dining was initiated for all residents requiring assistance with feeding. An additional dining area was set up in the multipurpose room of the facility to provide assisted dining along with independent and social dining in open areas with increased supervision. Those identified at high risk will be directly supervised during meals.  2. Identification of Others at Risk:  All residents could be considered potentially at risk for choking however, all residents		

F365 Continued

18a

were assessed for choking by Licensed Nursing Staff on March 21, 2012, utilizing observation and interview. (*See Residents at Risk for Choking Assessment form, exhibit 5a*).

### 3. Prevention Measures:

All Dietary staff were educated by the Registered Dietitian, or Certified Nutritionist, on March 28, 2012 and March 29, 2012, on Modified Texture Diets, with the objective to ensure safe preparation and service of a texture modified diet such as mechanical soft or pureed diet. A Pre-test and Post-test was administered regarding texture modification with all Dietary staff successfully completing the Post-test. Utilizing materials from the American Dietetic Association, the lesson was delivered by lecture, demonstration, and brainstorming activity. Any Dietary staff member not in attendance educated prior to their next shift by the Registered Dietitian or the Certified Nutritionist. (*See Dietary Inservice, Modified Texture Diets, Attachment #10 thru 10d.*)

All staff members were inserviced by the Registered Dietitian on March 29, 2012, on texture modified diets, the requirements and recognition of texture modifications. Any staff members not in attendance are educated prior to their next

F365 Continued

18b

shift by the Registered Dietitian, Certified Nutritionist or Licensed Nursing staff. New hires are trained in the initial orientation by the Corporate Nurse Trainer. *(See Dietary Inservice, Modified Texture Diets, Attachment #10 thru 10d.)*

Resident #2 and #3 were placed on one to one supervision by the DON for all meals and snacks on March 17, 2012, x 30 days and then directly supervised. All meals are monitored for correct texture by Licensed Staff, Registered Dietitian (RD) or Certified Nutritionist (CN), with snacks reviewed with the diet order and monitored by the Certified Medication Aides. *(See Meal and Snack Monitor Example Sheets, Attachment # 8 thru 8b.)*

All residents were reviewed by Licensed Nursing staff for choking or dysphagia related issues on March 21, 2012, with three residents determined to be at high risk for choking (this number includes residents #2 and #3). Dietary care plans reviewed and updated by the Registered Dietitian or Certified Nutritionist (CN) on March 29, 2012. The Dietary Staff prepares and serves the trays of identified high risk residents first at every meal as initiated on March 17, 2012, by the DON and the Administrator.

F365 Continued

18c

Direct supervision, also initiated March 17, 2012, is arranged prior to each meal by the Charge Nurse for each of the identified residents. *(See Resident's at Risk for Choking Assessment Form, Attachment #5a.)*

Diet orders and dietary care plans for all residents were reviewed by the Registered Dietitian (RD) and the Assistant Dietary Manager on March 29, 2012. All physician orders have been compared to tray cards and tray cards updated on March 29, 2012, by the RD and are reviewed by the RD and/or CN daily x 30 days then monthly x 3 months, with updates as needed. *(See Attachment # 8, 8a, & 8b, Meal Monitor Sheet.)*

On March 17, 2012, resident meal/tray direct observation was initiated for all resident diets in the kitchen at the point of tray origin. The observation is being completed 3 meals per day, 7 days per week, for a period of 30 days at the point of tray assembly by a Licensed Nurse, Registered Dietitian or Certified Nutritionist (CN). *(See Attachment #8, 8a, & 8b, Meal Monitor Form)*

On March 17, 2012, supervised dining, (supervised by NASR's, CMT's and Licensed staff), was initiated for all residents requiring assistance with feeding. An additional dining area

F365 Continued

18d

for residents requiring assistance with feeding was set up March 16, 2012, by the Maintenance and Housekeeping staff in the multipurpose room of the facility to provide assisted dining along with independent and social dining in open areas with increased supervision by NASR's, CMT's, and Licensed Nurses. Those identified by Licensed Nursing Staff at high risk are directly supervised by trained staff during meals. *(See Texture Modification Diets Accuracy Check, Attachment #9)*

**4. Monitor:**

Daily monitoring of trays continued for 30 days by licensed staff in the kitchen and the point of service and then monitored by trained Nursing and Dietary staff continuing. Reports of any issues are provided by the Licensed Staff and the Dietary Manager to the DON for review and then to the Administrator by the DON. Any problems will be corrected immediately and reported to the Corporate Registered Dietitian, the Corporate Compliance Nurse and the Administrator. The Administrator will report findings to the facility Quality Assurance Committee utilizing the Dining/Meal Review CQI tool weekly x 3 months, then monthly x 12 months and ongoing.

**5. Date corrected:**

4-11-12

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
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{F 365}	Continued From page 18	{F 365}			
{F 490} SS=E	<p>removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to administering the facility in such a manner to ensure residents received supervision related to behaviors and residents received food in a form that met their individual needs. However, non-compliance continued to exist at a S/S of a "E" as the Quality Assessment and Assurance (QAA) Committee had not completed monitoring, analysis of information and had not had an opportunity to develop and implement a Plan of Correction (POC), related to providing supervision to residents at risk for resident to resident abuse and residents received food in a form that met their individual needs.</p> <p>The findings include:  Review of the Acceptable Allegation of</p>	{F 490}	<p>F490</p> <p><b>1. Corrective Action:</b> <b>Residents #1, #2, #3, #4, #5, #6, #7</b></p> <p>Administrator confirmed with staff consultation and record review that any corrective action needed for these identified residents was completed and documented.</p> <p><b>Resident #1</b> was assessed by the MDS Coordinator and Social Services Director, utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities on March 29, 2012.</p> <p><b>Resident #1</b> placed on one to one supervision March 16, 2012.</p> <p>Care plans were reviewed and revised for <b>Residents # 1, 4, 5, 6 and 7</b> by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows:</p>		

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{F 490}	Continued From page 19 Compliance (AoC), dated 03/21/12, revealed the Corporate Compliance Nurse trained the facility Administrator in the reporting of all alleged violations involving mistreatment, neglect, and/or abuse. Further the need for evidence of a thorough investigation and proof of resident safety during the investigation process. Training also covered resident rights and the efforts the facility had in place to prevent abuse and ensure resident safety. The Corporate Compliance Nurse is monitoring the Administrator daily through a written report that includes any alleged incidents of mistreatment, neglect or abuse of residents. Any investigations initiated are reviewed by the Corporate Compliance Nurse to ensure a thorough investigation and appropriate reporting has been accomplished.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).	{F 490}	<del>F490 Continued</del>  Res #1 Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident Res #4 Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wandeguard Res #5 Diversional activities revised to include coloring, puzzles, and TV Res #6 Revised care plan on making false accusations, revised potential for verbal abuse include argumentative, interventions revised to include behavior activity box, and conversation Res #7 Changed diversional activities to conversing, TV, games and personalized activity box  MDS Coordinator and Social Services Director reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink,	
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  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.	{F 520}		

F490 Continued

20a

toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g*

**Res #2 and Res #3:** A nutritional review of Res #2 and Res #3, along with other residents, was conducted by the Registered Dietitian and the Assistant Dietary Manger on March 29, 2012. Diet orders and dietary/nutrition care plans were reviewed for any changes needed. Physician orders compared to tray cards and tray cards updated on March 29, 2012, by the RD.

On March 17, 2012, resident meal/ tray direct observation was initiated for all residents. The observation is completed 3 meals per day, 7 days per week, for a period of 30 days at the point of tray assembly and the point of tray service by a Licensed Nurse, RD or Certified Nutritionist.

Observation records are provided to the DON and the Administrator daily. Snacks are monitored and served by the Certified Medication Aides with documentation provided to the DON daily.

F490 Continued

20b

On March 17, 2012, supervised dining was initiated for all residents requiring assistance with feeding. An additional dining area was set up in the multipurpose room of the facility to provide assisted dining along with independent and social dining in open areas with increased supervision. Those identified at high risk will be directly supervised during meals.

Specialized training on utilizing Continuous Quality Improvement (CQI) Tools and monitors was scheduled with Pat Boyer and Associates for April 17, 2012 for The CQI Committee including Department Leaders and Supervisors.

**2. ID of Others at Risk:**

All residents considered to be at risk for abuse or incidental, occasional choking.

All residents assessed for abuse by Licensed Nursing Staff utilizing observation and interview. (*See Residents at Risk for Abuse Assessment form*).

All residents assessed for choking by Licensed Nursing Staff utilizing observation and interview. (*See Residents at Risk for Choking Assessment form, exhibit 5a*).

**3. Prevention Measures:**

Corporate Compliance Nurse trained Administrator on 3-21-12, regarding residents' right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. There must be evidence that

F490 Continued

20c

residents are protected from abuse and all alleged violations are thoroughly investigated and the facility must prevent potential abuse (verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion) of any resident. The Administrator is to ensure there is sufficient and adequate interventions in place for prevention of abuse.

Corporate Compliance Nurse to follow up on Administrator daily for a period of 30 days, and then visit on a weekly basis to follow-up on Administrative practices.

A monitor of the Behavior Observation Program (BOP) was established by the Social Services Director on March 29, 2012. BOP sheets are reviewed daily by the Social Services Director and/or the Charge Nurse x 30 days and then M-F in daily staff meetings with weekend or holiday reviewed on next business day for a 7 days per week review to determine if interventions have been successful and if care plans need to be reviewed and revised. Revisions in care plans and interventions will be made as needed by the Social Services Director or Charge Nurses. *(See BOP Monitor sheets, Attachment #1.)*

On March 17, 2012, supervised dining was initiated for all residents requiring assistance with feeding. An additional dining area was set up in the multipurpose room of the facility to provide assisted dining along with independent and social dining in open areas with increased supervision. Those identified at high risk will be directly supervised by staff during meals.

F490 Continued .

20d

On March 17, 2012, resident meal/ tray direct observation was initiated for all residents. The observation is completed 3 meals per day, 7 days per week, for a period of 30 days at the point of tray assembly and the point of tray service by a Licensed Nurse, RD or Certified Nutritionist.

Observation records are provided to the DON and the Administrator daily. Snacks are monitored and served by the Certified Medication Aides with documentation provided to the DON daily.

Daily monitoring of trays will continue for a period of 30 days by licensed staff in the kitchen and the point of service. Monitoring will then become the responsibility of trained staff in Nursing and Dietary. Reports are provided by the Licensed Staff to the DON for review and then to the Administrator by the DON. Any problems will be corrected immediately and reported to the Corporate Registered Dietitian (RD), the Corporate Compliance Nurse and the Administrator. The Administrator or RD will report findings to the facility's Continuous Quality Improvement Committee utilizing the Dining/Meal Review CQI tool weekly x 3 months, then monthly x 12 months and ongoing.

#### 4. Monitor:

All resident incident reports are reviewed with the Administrator and in regularly scheduled Morning Staff Meetings M-F with weekend incidents reviewed on Monday. Any incident reports containing allegations of abuse will be forwarded to the Concord Health Systems Corporate Office for review by the Corporate Compliance Nurse to assure that identification and the protection of the resident, investigation and reporting have been accomplished correctly by the Administrator.

F490 Continued

20e

Corporate Compliance Nurse to visit on a weekly basis to follow-up on Administrative practices. Progress will be reported in the monthly Corporate Quality Assurance staff meetings via the Compliance Nurse monthly report and any compromising issues will be handled immediately.

Daily monitoring of incident reports by Administrative Nurses (DON, Administrative LPN's) that include investigation and supervision information (including incidents of abuse and choking) implemented 7 days per week (M-F and Weekend and holidays reviewed on next business day) for three months. Any problems will be reported immediately to the Corporate Compliance Nurse for action. Information is also reported to the ADM by the DON. The Administrator or DON reports incident tracking to the facility Continuous Quality Improvement Committee M-F and called meetings as necessary on weekends or holidays and in regular monthly meetings. The Committee consists of the Administrator, DON, Administrative Nurses, Social Services Director, Medical Director, Dietary Director, Activities Director, Maintenance Director, Human Resources Director, and the Environmental Services Director.

5. Date Corrected:

4-11-12

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(F 520)	<p>Continued From page 20</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 03/22/12, had been removed related to supervision to prevent resident to resident abuse and food was provided to residents according to their identified needs. However, non-compliance continued to exist at a S/S of a "E" as the facility had not completed the Quality Assessment and Assurance (QAA) Initiative related to staff training on the facility's abuse policy and procedure and the development and implementation of the Plan of Correction (POC), as related to supervision to prevent resident to resident abuse and food was provided to residents according to their identified needs.</p> <p>The findings include:</p>	(F 520)	<p><b>F520</b> <b>Residents #1, #2, #3, #4, #5, #6 &amp; #7</b></p> <p><b>1. Corrective Actions:</b></p> <p>Administrator confirmed with staff consultation and record review that any corrective action needed for these identified residents was completed and documented.</p> <p>Resident #1 was assessed by the MDS Coordinator and Social Services Director, utilizing the resident's history and diagnosis criteria, to identify behaviors for behavior management opportunities on March 29, 2012.</p> <p>Resident #1 placed on one to one supervision March 16, 2012.</p> <p>Care plans were reviewed and revised for Residents # 1, 4, 5, 6 and 7 by the Social Services Director and MDS Coordinator on March 29, 2012 to include updated behavior interventions and approaches as follows:</p>	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 04/10/2012
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
(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 520}	Continued From page 21  Review of the Acceptable Allegation of Compliance (AoC), dated 03/21/12, revealed the Administrator is to report information on behaviors gained from Charge Nurse Compliance Rounds to the Quality Assurance (QA) Committee Monday through Friday and with called meetings as needed on weekends and holidays. The Committee members include the Administrator, the DON, Administrative Nurses, Social Services Director, Dietary Director or Assistant, Activities Director, Maintenance Director, Human Resources Director, and the Environmental Services Director. As of 03/29/12, the QA Committee has reviewed all monitoring results related to nurse aide rounds, charge nurse compliance rounds, daily monitoring of incident reports, and the daily Behavior Observation Program (BOP) sheets.  Related to dietary efforts, the QA Committee has reviewed all monitoring results to include diet trays check by licensed staff prior to presentation to resident, tray checks in the kitchen, dietary care plan changes and diet orders, and observation records logged by the Registered Dietitian or Certified Nutritionist.  Interview with the Administrator, on 04/10/12 at 2:45 PM, revealed the facility was continuing to monitor and discuss concerns identified during rounds so they could be addressed with the QA committee and deficient practice could be removed. She stated the facility had not had an opportunity to develop and implement a Plan of Correction (PoC) as the facility had not received the Statement of Deficiencies (SoD).	{F 520}	F520 Continued  Res #1 Diversional activities were revised to include reading the Bible, singing, writing cards, and providing personalized behavior/activity box that includes craft items for making cards and other items of interest to the resident Res #4 Diversional activities revised to include offer snack food, conversation and providing personalized behavior/activity box, and d/c of dealing with Wanderguard Res #5 Diversional activities revised to include coloring, puzzles, and TV Res #6 Revised care plan on making false accusations, revised potential for verbal abuse include argumentative, interventions revised to include behavior activity box, and conversation Res #7 Changed diversional activities to conversing, TV, games and personalized activity box  MDS Coordinator and Social Services Director reviewed and revised Behavior Observation Program (BOP) sheets and the Nurse Aide Care Plans for all residents on March 29, 2012 to include new intervention suggestions available to the Nurse Aides and other staff members to include offer food, drink,		

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toilet, reposition, verbal cues, redirect, offer activity, remove from environment. If unsuccessful, Charge Nurse will be notified to assess for additional interventions or 1:1 supervision. *(See Behavior Observation Tracking Sheets, Attachment #1 thru 1g*

**Res #2 and Res #3:** A nutritional review of Res #2 and Res #3, along with other residents, was conducted by the Registered Dietitian and the Assistant Dietary Manger on March 29, 2012. Diet orders and dietary/nutrition care plans were reviewed for any changes needed. Physician orders compared to tray cards and tray cards updated on March 29, 2012, by the RD.

**Res #2** Placed on supervised dining on March 17, 2012

**Res #3** Placed on supervised dining on March 17, 2012

By compliance date, supplemental training related to behaviors and continuous quality improvement scheduled ongoing with professional healthcare consultant group for the Social Services Director (SSD), along with licensed staff and management. This is a nationally recognized group specializing in the provision of long term care consulting and education.

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**2. ID of Other Residents at Risk:**

All residents considered to be at risk for abuse or incidental, occasional choking.

All residents assessed for abuse by Licensed Nursing Staff utilizing observation and interview. (*See Residents at Risk for Abuse Assessment form*).

All residents assessed for choking by Licensed Nursing Staff utilizing observation and interview. (*See Residents at Risk for Choking Assessment form, exhibit 5a*).

**3. Prevention:**

Any issues related to meals or behaviors are referred to the Charge Nurse and then daily to the Continuous Quality Improvement (CQI) meeting by licensed staff or DON who receives information from Charge Nurse. The CQI team utilizes Plan, Do, Study and Act (PDSA) as the model or system for the review process Monday –Friday with incidents from the weekend reviewed on Monday or a called meeting as deemed necessary by Administrator or DON for any incident including but not limited to choking or abuse.

The Continuous Quality Improvement Committee has increased meetings and monitoring to daily reviews x 30 days as of March 22, 2012, (M-F with weekends and holidays reviewed on the next business day or a called meeting if deemed necessary by the Administrator, DON or Corporate Nurse) for the review of Behavior Observations and care planning as well as incidents within the facility that are reviewed daily, ongoing. Any issues are investigated and handled in a timely manner.

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Additional training scheduled April 16<sup>th</sup> & 17<sup>th</sup>, 2012, with Pat Boyer and Associates for the Social Services Director (SSD), the Continuous Quality Improvement (CQI) Team, along with licensed staff and management. This is a nationally recognized group specializing in the provision of long term care consulting and education. The Boyer training will address:

1. Behavior management by the SSD and other staff of residents with psychiatric diagnoses and aggressive behaviors.
2. SSD and other staff implementing interventions to protect residents from harm
3. The effective use of care plans and interventions by the SSD and other staff
4. Patient counseling, remedies by SSD
5. SSD reporting and investigating complaints
6. Physician contact when needed by SSD and licensed staff
7. Resident assessment by the SSD and other staff
8. Staff training by the SSD

A special session is also scheduled with Pat Boyer and Associates on March 17, 2012 regarding CQI Tools and Monitoring for the CQI Team.

All Dietary staff were educated by the Registered Dietitian, or Certified Nutritionist, on March 28, 2012 and March 29, 2012, on Modified Texture Diets, with the objective to ensure safe preparation and service of a texture modified diet such as mechanical soft or pureed diet. A Pre-test and Post-test was administered regarding texture

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modification with all Dietary staff successfully completing the Post-test. utilizing materials from the American Dietetic Association, the lesson was delivered by lecture, demonstration, and brainstorming activity. Any Dietary staff member not in attendance educated

prior to their next shift by the Registered Dietitian or the Certified Nutritionist. (*See Dietary Inservice, Modified Texture Diets, Attachment #10 thru 10d.*)

All staff members were inserviced by the Registered Dietitian on March 29, 2012, on texture modified diets, the requirements and recognition of texture modifications in order to assure accuracy of trays being served. Any staff members not in attendance are educated prior to their next shift by the Registered Dietitian, Certified Nutritionist or Licensed Nursing staff. New hires are trained in the initial orientation by the Corporate Nurse Trainer. (*See Dietary Inservice, Modified Texture Diets, Attachment #10 thru 10d.*)

#### 4. Monitor:

Daily reports are sent to the Corporate Compliance Nurse x 30 days and then visits scheduled weekly for ongoing monitoring. A summary of incidents are reviewed monthly in the facility's regularly scheduled CQI Meeting as well as the Corporate Quality Assurance/ CQI monthly meeting.

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Daily monitoring of incident reports by Administrative Nurses (DON, Administrative LPN's) that include investigation and supervision information (including incidents of abuse and choking) implemented 7 days per week (M-F and Weekend and holidays reviewed on next business day) for three months. Any problems will be reported immediately to the Corporate Compliance Nurse for action. Information is also reported to the ADM by the DON. The Administrator or DON reports incident tracking to the facility Continuous Quality Improvement Committee M-F and called meetings as necessary on weekends or holidays and in regular monthly meetings. The Committee consists of the Administrator, DON, Administrative Nurses, Social Services Director, Medical Director, Dietary Director, Activities Director, Maintenance Director, Human Resources Director, and the Environmental Services Director.

5. Date Corrected:

4-11-12