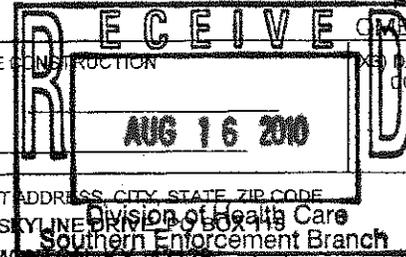


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second SOD

PRINTED: 08/11/2010
FORM APPROVED
FORM NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 8/15/2010
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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42125
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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 A standard health survey was conducted on July 13-15, 2010. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY14811) was also conducted at this time. The allegation was substantiated and deficient practice was identified.	F 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	F 156	1. The ABN notices for residents #9, 19, 20, 21, and 22 were re-completed on the current ABN forms which include the resident appeal rights and verification of notice information, with the blanks completed to specify the reason for the anticipated non-coverage. The revised notices were provided to these residents or their responsible party as indicated, with education on the need to check the box of their choice and complete the information verifying notice of the information related to the change in payor source. 2. The ABN notices for the last 3 months have been audited by the Administrator and Business Office Manager to determine that all were completed to specify the reason for the anticipated non-coverage and that information was provided on the resident appeal rights and verification of notice related to the change in payor source. The revised notices were provided to these residents or their responsible party as indicated, with education provided on the need to check the box of their choice and complete the information verifying notice of the information related to the change in payor source. 3. The ABN notices will now be completed by the Business Office Manager. The BOM has received in-service education on the accurate.	8/16/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amy Neighbor</i>	TITLE Administrator	(X5) DATE 8/16/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements</p>	F 156	<p>completion on the ABN notices and the need to fill in the blanks as provided by the Corporate Consultant on July 20, 2010.</p> <p>4. The CQI indicator for the monitoring of the ABN form use will be utilized monthly X 2 months and then as per the established CQI calendar under the supervision of the BOM.</p>	

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F 156	<p>Continued From page 2</p> <p>specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to include the verification of receipt of a Notice of Medicare Provider Non-Coverage denial and/or failed to include acknowledgement of information regarding procedures for an appeal in the denial notice for (5) five of five (5) residents (residents #9, #19, #20, #21, and #22) that had received a denial notice.</p> <p>The findings include:</p>	F 156			

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F 156	Continued From page 3 1. A review of the denial notices for non-Medicare coverage for residents #9, #19, #20, #21, and #22 revealed that the notices sent to the resident/responsible party failed to include verification of receipt of the notice and/or failed to include acknowledgement of the information regarding procedures for an appeal in the denial notice. An interview conducted with the Social Services Director (SSD) on July 15, 2010, at 3:30 p.m., revealed the SSD was responsible for issuing the denial notices to the residents/responsible parties. The SSD stated the denial notices were routinely mailed to the resident/responsible party a couple of days prior to the end of the Medicare coverage date. The SSD stated no formal cover letter was sent with the notice, but a handwritten note was included to request the resident/responsible party to sign and return the notice to the facility. The SSD stated no additional information was provided to the resident/responsible party regarding appeal rights.	F 156			
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.	F 202	1. Physician documentation regarding the reason for discharge for resident #14 had been completed as a late addendum to the record. 2. The transfer/discharges for the last 3 months have been reviewed by the discharge team to determine that the required documentation has been completed. All required documentation was identified. 3. The facility discharge team (Administrator, DON, Director of Social Services) have received in-service education on the documentation requirements for transfers/discharges as provided by the Corporate Consultant on July 20, 2010.	8/16/10	

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F 202	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's physician documented the reason one (1) of twenty-two (22) sampled residents (resident #14) was discharged from the facility.</p> <p>The findings include:</p> <p>A review of the nurse's notes for resident #14 revealed on April 21, 2010, at 12:00 p.m., resident #14 cornered and attempted to kiss a housekeeping staff person. The nurse's notes also revealed resident #14 threatened to "snap the jugular of another resident." The Social Services Director was notified at 1:15 p.m., of the incident. According to the nurse's notes, resident #14 was discharged from the facility and transferred home by cab on the afternoon of April 21, 2010. The resident's family and physician were notified.</p> <p>An interview conducted with a Registered Nurse (RN) on July 15, 2010, at 9:55 a.m., revealed that a housekeeping staff member had reported that resident #14 had tried to kiss and "grope" her and threatened to harm another resident on April 21, 2010, at 12:00 p.m. According to the RN, the Social Services Director was immediately notified. The Administrator and Director of Nurses (DON) were contacted and it was determined that resident #14 was to be discharged immediately from the facility. According the RN, the resident's physician was notified by fax that the resident was going to be discharged from the facility.</p> <p>An interview conducted with the Social Services Director on July 14, 2010, at 1:50 p.m., revealed</p>	F 202	4. The CQI indicator for the monitoring of transfer/discharge documentation will be utilized monthly X 2 months and then as per the established CQI calendar under the supervision of the Administrator.	

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F 202	<p>Continued From page 5</p> <p>resident #14 had an episode of inappropriate behavior toward a staff member and threatened to harm another resident on April 21, 2010, at 12:00 p.m. The Social Services Director informed the Administrator and the DON of the resident's behavior and a decision was made to issue a discharge notice to resident #14. According to the Social Services Director, the resident was issued a discharge notice and the resident's family was contacted. The family was unable to come to transport the resident and the facility arranged transportation for resident #14.</p> <p>An interview conducted with resident #14's Physician of Record on July 15, 2010, at 2:00 p.m., revealed the physician could not recall talking with the facility regarding the discharge of resident #14, however, had received a facsimile from the facility regarding the discharge of resident #14 on April 21, 2010, at 1:48 p.m. The physician stated that resident #14 had "fired" his previous physician and was angry at the current physician. The physician stated the resident would not comply with the physician's recommendations. Further interview with resident #14's physician revealed the physician had signed the discharge order but had not documented in resident #14's clinical record the reason for the resident's discharge.</p> <p>A review of the Notice of Transfer and Discharge form dated April 21, 2010, revealed the resident was discharged from the facility due to "The health of individuals in the facility is being endangered."</p> <p>A review of the facility policy (RC-2.12) regarding resident transfer and discharge rights (not dated) revealed if a resident was discharged from the</p>	F 202			

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F 202	Continued From page 6 facility because the health of individuals in the facility would otherwise be endangered the basis of the discharge must be documented in the resident's clinical record by a physician.	F 202			
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 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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	F 225	1. The State Agency was made aware of the missing items for resident #18 during the survey. DCBS was notified of the missing items on July 21, 2010. The allegation of misappropriation of property for resident #18 was investigated by the Administrator and found to be unsubstantiated. The findings were reported to the resident/family and the money was provided to the resident by the facility. 2. An audit was completed by the Administrator of all resident reports of missing items for the last 3 months to determine notification of the required state agencies. 3. In-service education was provided for the Administrator on the need to report and investigate missing items as allegations of potential misappropriation of property as provided by the Corporate Consultant on July 20, 2010. 4. The CQI indicator for the monitoring of reporting and investigating of misappropriation of property will be utilized monthly X 2 months and then as per the established CQI calendar under the supervision of the Administrator.	8/16/10	

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F 225	<p>Continued From page 7</p> <p>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 and record review, it was determined the facility failed to ensure all allegations involving misappropriation of resident property were investigated and reported to the appropriate state agencies for one (1) of twenty-two (22) sampled residents (resident #18).</p> <p>The findings include:</p> <p>During a resident group meeting conducted on July 13, 2010, at 3:00 p.m., resident #18 verbalized concerns related to missing cosmetics and money. The resident stated missing items of makeup and money were reported to facility staff. The resident further stated the facility staff did not replace missing items nor did the facility inform her of the outcome of the report.</p> <p>An interview conducted on July 14, 2010, at 1:25 p.m., with resident #18 revealed when resident #18 made a deposit into her bank account at the facility (unable to recall exact date) money in the amount of nine dollars and twenty-five cents (\$9.25 in quarters) was missing. Resident #18 reported missing money to the Business Office Manager and the Administrator. Although resident #18 could not give an exact date the items disappeared, the resident stated that it had been in the last two months.</p> <p>The facility's policy/procedure for Missing Items/Misappropriation of Resident Property (no</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>date) required all reports of misappropriation of resident property be investigated and looked at by the supervisor.</p> <p>A review of the facility's abuse policy/procedure (no date) revealed misappropriation of resident property was defined as "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent." However the abuse policy/procedure did not include guidance related to investigation and reporting allegations of misappropriation of resident property.</p> <p>An interview with the Facility Administrator conducted on July 14, 2010, at 2:20 p.m., revealed a grievance was filed by resident #18 for missing cosmetics and was investigated, however, no grievance was filed, nor investigation conducted, for missing money. In addition, the Administrator stated, "The missing money was discussed, however, I did not feel she was telling me the money was missing or wanted me to do anything about it."</p> <p>A review of a grievance report dated May 27, 2010, was filed by resident #18. The grievance report contained an investigation of reported missing cosmetics, however, the grievance report failed to list an investigation of reported missing money.</p> <p>An additional interview conducted on July 15, 2010, at 12:30 p.m., with the Facility Administrator revealed the facility had failed to investigate resident #18's report of missing money. The Administrator also reported the facility failed to report to the proper state agencies</p>	F 225			

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F 225	Continued From page 9 regarding resident #18's missing cosmetic and money.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 and record review, the facility failed to develop policies and procedures related to the reporting/investigating of allegations of injuries of unknown source and misappropriation of resident property (refer to F225). The findings include: Record review of the policy and procedure regarding abuse and neglect (not dated) revealed no evidence the facility included the investigation and reporting section of the policy to include injury of unknown source and misappropriation of resident property. Interview with the Administrator on July 15, 2010, at 1:35 p.m., confirmed the facility's policy and procedure titled "Resident Abuse" did not address investigation and reporting regarding injury of unknown source and misappropriation of resident property.	F 226	1. The State Agency was made aware of the missing items for resident #18 during the survey. DCBS was notified of the missing items on July 21, 2010. The facility abuse policy was revised to specifically address the reporting and investigation of allegation of misappropriation of resident property. 2. An audit was completed by the Administrator of all resident reports of missing items for the last 3 months to determine notification of the required State agencies for any allegation of misappropriation of resident property. Residents were also asked by the during the resident council meeting on 8/12/10 if they had any missing items that needed to be reported for investigation. 3. In-service education was provided for the Administrator on the need to report and investigate missing items as allegations of potential misappropriation of property as provided by the Corporate Consultant on July 20, 2010. 4. The CQI indicator for the monitoring of reporting and investigating of misappropriation of property will be utilized monthly X 2 months and then as per the established CQI calendar under the supervision of the Administrator.	8/16/10	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medicaly-related social services to attain or maintain the highest	F 250	1. Resident #14 no longer resides at the facility. 2. The discharges for the last 3 months have been reviewed by the discharged team to determine that the necessary discharge planning services	8/16/10	

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F 250	<p>Continued From page 10</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide medically-related social services to attain/maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of twenty-two (22) sampled residents (resident #14). Resident #14 was issued a discharge notice and was discharged from the facility on April 21, 2010. There was no evidence the facility assessed resident #14 for medically related social services related to discharge planning to include scheduling consultations/follow-up physician appointments and obtaining medications.</p> <p>The findings include:</p> <p>A review of the medical record for resident #14 revealed the resident was a 63-year-old alert and oriented resident who was admitted to the facility on February 25, 2010. A review of the most recent diagnosis for resident #14 revealed diagnoses of Ischemic Cardiomyopathy with Severe Congestive Heart Failure, Insulin Dependent Diabetes Mellitus, and Congestive Obstructive Pulmonary Disease. Resident #14 required multiple medications daily and, in addition, required the use of Novolin N Insulin. Resident #14 took 20 units of Novolin N Insulin daily via injection and was prescribed additional Regular Insulin to be administered according to the resident's blood glucose level. Further review of the record revealed on April 21, 2010, at 1200</p>	F 250	<p>have been provided as indicated by the discharge team.</p> <p>3. The discharge team has received in-service education on the need to determine that the necessary discharge planning services are provided for residents as indicated by the discharges plans, as provided by the Corporate Consultant on July 20, 2010.</p> <p>4. The CQI indicator for the monitoring of discharge planning services will be utilized monthly X 2 months then every 6 months as per the established CQI calendar, under the supervision of the Administrator.</p>		

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F 250	<p>Continued From page 11</p> <p>p.m., resident #14 displayed inappropriate behavioral symptoms with facility staff and threatened to harm another resident. Resident #14 was issued a discharge notice and discharged from the facility on April 21, 2010, at 2:35 p.m.</p> <p>A review of a recent psychiatric evaluation for resident #14 dated April 7, 2010, revealed the resident was diagnosed with Intermittent Explosive Disorder. According to hospital discharge instructions dated April 20, 2010, resident #14 was diagnosed with Paranoid Schizophrenia and was to follow up with a psychiatrist as recommended by the resident's primary care physician.</p> <p>An interview conducted with a family member of resident #14 on July 14, 2010, at 1:40 p.m., revealed the facility had contacted the family member on April 21, 2010. The facility relayed to the family member that resident #14 was being discharged from the facility due to threatening another resident. According to the family member, the facility requested the family transport resident #14 home. The family member told the facility no one was available to transport resident #14. Resident #14 was sent to the family member's house by medical transportation with no medications. Resident #14 was not able to obtain medications due to still being in the nursing home system. Further interview revealed the facility had not made follow-up appointments for resident #14 or asked to see if the family was able to provide care for resident #14.</p> <p>An interview conducted with a Registered Nurse (RN) revealed the nurse had reviewed resident #14's discharge instructions with the resident and</p>	F 250			

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F 250	Continued From page 12 the resident voiced understanding. Further interview revealed the RN had faxed the resident's medication list to the pharmacy. The RN was not aware if resident #14 was able to perform blood glucose checks and administer insulin. Further interview revealed the RN had not scheduled follow-up appointments with a primary care physician or a psychiatrist. An interview conducted with the Social Services Director (SSD) on July 15, 2010, at 11:30 a.m., revealed the SSD had contacted resident #14's family on April 21, 2010, regarding the discharge of resident #14. Additional interview revealed the facility had previously scheduled an inpatient psychiatric visit for resident #14; however, the resident and his family refused this referral. The SSD was informed by the resident's family member that resident #14 wanted to go home. The SSD had not arranged for any additional services for resident #14 related to discharge nor had conducted any discharge planning related to the care needs of resident #14 on April 21, 2010, before the resident was discharged from the facility.	F 250			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	1. Resident #4 has had review/revision of the care plan to address interventions related to communication. Residents #1 & 11 have had review/revision of their care plans to address interventions related to their +PPD status. 2. The MDS nursing staff have completed an audit of the current residents to identify those with communication needs and +PPD status. There were no other residents identified with communication needs. All residents with +PPD status have had review/revision of their care plans to address interventions related to their +PPD status.	8/16/10	

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F 279	Continued From page 13 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to develop a comprehensive care plan to meet the medical, nursing, and nutritional needs for three (3) of twenty-two (22) sampled residents	F 279	3. The MDS nurses have received in-service education on the need to address communication needs and +PPD status on the care plans of residents with these conditions as provided by the Corporate Consultant on August 3, 2010. 4. The CQI indicator for the monitoring of care plan development will be utilized monthly X 2 months and then as per the established CQI calendar, under the supervision of the Director of Nursing.
	(residents #1, #4, and #11). Resident #4 was admitted to the facility with a diagnosis of deaf/mute; however, the facility failed to develop an individualized plan of care related to communication for resident #4. Resident #1 and resident #11 were admitted with a history of being PPD positive; however, the facility failed to develop an individualized care plan to address the residents' positive PPD status. The findings include: 1. A review of the medical record for resident #4 revealed the resident was admitted to the facility on June 3, 2004, with diagnoses that include Deaf/Mute, Aphasia, Penile Cancer, and Gastroesophageal Reflux Disease. A review of the comprehensive care plan revealed the facility had identified resident #4 had a problem with impaired communication related to		

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F 279	<p>Continued From page 14</p> <p>being deaf/mute. The facility's approaches were to speak in a calm and gentle tone, speak directly into line of vision, allow sufficient time to finish nonverbal communication, and to anticipate and meet needs on direct personal knowledge. However, a review of the Minimum Data Set (MDS) supplemental assessment dated April 16, 2010, revealed resident #4 had been assessed to use gestures and sounds to communicate. The assessment reflected that routine staff can sometimes understand the resident and the resident's ability was limited to making concrete requests regarding at least basic needs (i.e. food, drink, sleep, and toilet).</p> <p>Observation of resident #4 at 5:10 p.m. (CDT) on July 13, 2010, revealed the resident was in the sun room for the evening meal. The resident received food that was pureed consistency. In addition, resident #4 had a bowl of corn flakes. The resident immediately began eating the cornflakes after staff put sugar and milk on the cereal. Once the resident was finished eating the cornflakes, the resident took only two bites of the pureed food and did not eat any more from the plate. Resident #4 motioned with hands to the surveyor and pointed at the empty cereal bowl. Six staff members were in the sun room assisting other residents. However, none of the staff came to resident #4 regarding the resident motioning with the hands and pointing at the empty cereal bowl until surveyor intervention. The surveyor requested staff to interpret what resident #4 was indicating with the motioning of the hands and pointing at the empty cereal bowl. After several attempts to understand what the resident was indicating, staff decided to get the resident another bowl of cornflakes. Resident #4 consumed a total of three bowls of cornflakes for</p>	F 279			

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F 279	<p>Continued From page 15 that meal.</p> <p>An interview was conducted with the MDS Coordinator at 12:00 p.m. on July 15, 2010. The MDS Coordinator stated that the comprehensive care plan for resident #4 was not individualized to meet the communication needs for resident #4. The MDS nurse stated that the facility had not identified any individualized interventions for resident #4. The nurse further stated the current comprehensive care plan for resident #4 was the original care plan that had been in effect since July 6, 2004. In addition, the MDS nurse stated the comprehensive care plan for resident #4 had not been individualized since the original care plan was implemented on July 6, 2004.</p> <p>An interview was conducted with the charge nurse on the 100 East Unit at 3:15 p.m. on July 14, 2010, regarding communication with resident #4. The charge nurse stated when resident #4 wanted more to eat, the resident would motion with the hands and point. However, some of the direct care staff found it difficult to communicate with resident #4.</p> <p>An interview was conducted with the Registered Dietitian (RD) at 8:40 a.m. on July 14, 2010. The RD stated resident #4 had always eaten cornflakes with every meal. However, the RD stated staff had not determined an efficient way to communicate with resident #4 when the resident was still hungry.</p> <p>An interview was conducted at 12:10 p.m. on July 14, 2010, with two direct care staff members for resident #4. The CNAs stated that resident #4 always received cornflakes every meal. However, the two CNAs said resident #4 rarely indicated the</p>	F 279			

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F 279	<p>Continued From page 16</p> <p>resident wanted more to eat.</p> <p>2. Review of the medical record revealed resident #1 was admitted to the facility on January 2, 2009, with diagnoses of intractable Back Pain, Sciatica, Ataxia, and Rheumatoid Arthritis. Review of a significant change in status assessment (SCSA) dated June 11, 2010, revealed the facility assessed resident #1 as having modified independence in cognition related to daily decision-making.</p> <p>Further review of the record revealed resident #1's medical record was flagged with a yellow dot that was marked indicating resident #1 was PPD+. Review of the comprehensive care plan revealed the facility had failed to develop an individual care plan related to resident #1's positive PPD status. Therefore, no interventions were implemented to guide staff related to the development of signs and symptoms of tuberculosis or to direct the care needs of resident #1 related to the positive PPD status.</p> <p>3. Review of the medical record revealed resident #11 was readmitted to the facility on September 10, 2007, with medical diagnoses of Aphonic, Congestive Heart Failure, Closed Head Injury, Seizure, History of GI Bleed, Spastic Quadriplegic, and Depression.</p> <p>Further review of resident #11's medical record revealed the medical record was flagged on the cover with a yellow dot marked with positive PPD. Review of the comprehensive care plan revealed the facility failed to develop an individual care plan for resident #11's positive PPD status. Therefore, no interventions were implemented to guide staff to assess for the development of signs</p>	F 279			