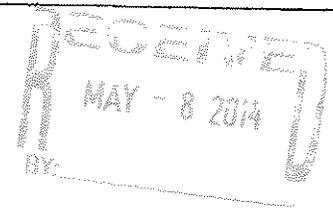


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/08/2014
NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An Abbreviated Survey investigating ARO #KY00021487 was initiated on 04/02/14 and concluded on 04/08/14. Deficient practice was cited at the highest scope and severity of an "E."	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure care plans were reviewed and revised after each incident for two (2) of ten (10) sampled residents (Residents #5 and #7). Resident #5 suffered a fall on 03/31/14, for which no	F 280	F280  1. On 04/09/2014 Resident #5 care plan was revised to reflect the intervention that was put in place after the fall on 03/30/2014, which included discontinuation of the tab alarm and a sensor pad alarm being put in place.  On 04/09/2014, Resident #5 care plan was revised to reflect the immediate intervention that was implemented on 03/31/14, after a fall. The immediate intervention was communicated to staff by verbal communication and by placing the intervention on the CNA Care Plan. The immediate intervention included the staff being educated on providing activities of interest for Resident #5 to redirect Resident #5 from attempting to rise from chair without assistance and divert her anxious behavior.	5/10/14



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Silma Hudson*

TITLE  
*Administrator*

(X6) DATE  
*5/8/14*

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

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F 280	Continued From page 1 intervention was documented on the Interim Care Plan. Resident #7 was placed on fifteen (15) minute checks after a resident to resident confrontation on 03/17/14, however, his/her care plan did not detail the fifteen (15) minute checks that were put into place following the confrontation.  The findings include:  Review of the facility policy titled, "Care Planning", dated December 2010 revealed the Plan of Care was to be individualized based on resident assessment, and staff was to document the plan of care, treatment and services. Further review revealed staff was to regularly review and revise the Plan of Care, treatment and services.  1. Review of Resident #5's medical record revealed Resident #5 was admitted to the facility on 03/24/14 with diagnoses of Anxiety State NOS, Dementia With Behavioral Disturbance, and Psychosis NOS. Additionally, Resident #5 was identified on his/her Interim Plan of Care, dated 03/24/14, as a fall risk. Admission Nurse's Notes for 03/24/14 revealed Resident #5 was admitted with a self-releasing lap buddy and alarm to his/her wheelchair, and also revealed Resident #5 was attempting to stand without assistance and as being redirectable only for short periods of time.  Observation of Resident #5 on 04/02/14 at 10:30 AM revealed Resident #5 kept attempting to rise up from his/her wheelchair, setting off his/her pressure alarm, despite therapy staff attempting to engage resident in mnemonic activities. After approximately ten (10) minutes of failed attempts to engage Resident #5 in activity, therapy staff	F 280	On 04/09/2014, Resident #7 Care Plan was revised to reflect the Q15 minute checks that were initiated on 03/18/2014.  2. On 04/08/2014 a complete review of all care plans was initiated by Regional Nurse Consultants, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, Unit Managers, Evening Shift Supervisor, and Restorative Nurse and was completed on 04/11/2014. The review was to ensure that all care plans were implemented and revised according to any change in condition noted and each Resident's needs, which included appropriate interventions for all accidents and incidents for the past 90 days.  3. All licensed nursing staff was educated on 4/10/14 related to implementation of immediate interventions for all accidents and incidents and revision of resident care plans. All nursing staff was educated on 4/10/14		

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F 280 Continued From page 2  
wheeled Resident #5 over to the central area of the dayroom where other residents were engaged in activities. Resident #5 continued to attempt to rise, while repetitively stating "Jesus loves me" or at times "Jesus help me".

Review of Resident #5's nursing assessments revealed he/she experienced three (3) falls from his/her date of admission, 03/24/14 through 04/02/14. Resident #5's first fall was on 03/25/14 at 12:45 PM, at which time Resident #5 was found on the floor at bedside with no injury and no witness to the fall. Review of the Interim Plan of Care revealed a bed alarm was placed on Resident #5's bed, and a referral to physical therapy and occupational therapy was made. Further review of the Interim Care Plan revealed anti-tippers were added to Resident #5's wheelchair on 03/27/14. Resident #5 experienced a second fall on 03/30/14 at 3:45 PM, at which time Resident #5 was again found at bedside without injury. The nursing assessment revealed a sensor alarm replaced the tab alarm that had been on Resident #5's bed at that time, although review of the Interim Care Plan revealed no change, and the Interim Care Plan was not updated after this fall. Resident #5 experienced a third fall on 03/31/14 at 11:30 AM in the dayroom, which was witnessed by staff, at which time Resident #5 suffered a laceration to his/her forehead, to the bridge of the nose, and a skin tear to his/her left wrist. Further review of Resident #5's medical record revealed he/she received sutures for his/her lacerations in the local emergency room and was returned to the facility. The nursing assessment revealed no new nursing interventions were added, and review of the Interim Care Plan revealed no changes following the fall.

F 280 related to the care planning process including updating the CNA's care plan to reflect any revisions from a change in condition. All orders will be reviewed Monday thru Friday in the morning clinical meetings to ensure proper care planning of any change in condition to reflect the resident's needs and proper interventions are implemented and care planned for all accidents and incidents. All accidents and incidents are then brought to the morning stand up meeting Monday thru Friday to review the intervention implementation, effectiveness, and care planning.

4. The DON, ADON, or Unit Managers will review all care plans to ensure any change in condition is care planned or revised as needed daily, Monday thru Friday for two weeks, and the process will be completed on Saturday and Sunday by the weekend supervisor beginning on May 10, 2014. Then, the DON, ADON, or Unit Managers will review 5 random Resident care

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F 280

Continued From page 3

Interview with Licensed Practical Nurse (LPN) #1 on 04/03/14 at 9:38 AM revealed following Resident #5's falls on 03/30/14 and 03/31/14, the facility put in a request for another physical therapy screen, which was standard practice when a resident had a fall. LPN #1 revealed the request for physical therapy screen should have been reflected on the care plan, and that any staff could have updated the interim care plan. LPN #1 revealed the nurse that put in the request should have updated the care plan.

Interview with Registered Nurse (RN) #2 on 04/06/14 at 3:05 PM revealed on 03/31/14 after Resident #5's third fall, she made sure to ask the Director of Nursing (DON) if there was anything else they could be doing to help Resident #5, and shared the DON said to make sure to do more activities with Resident #5 and get him/her more involved, information which RN #2 stated she shared with the State Registered Nursing Assistants (SRNAs). RN #2 revealed she didn't know for certain if the care plan was re-evaluated but said it should have been revised.

2. Review of Resident #7's medical record revealed Resident #7 was admitted to the facility on 01/07/14 with diagnoses which included Alzheimer's Disease, Dementia NOS With Behavioral Disturbance, and Psychosis NOS. The facility assessed Resident #7, in a Significant Change Minimum Data Set (MDS) dated 02/21/14, as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 04/15, indicating severe cognitive impairment. Further, the facility assessed Resident #7 as having delusions and exhibiting physical behavior directed towards others.

F 280

plans from all units weekly for four weeks, then 3 per week for four weeks, and then 2 monthly for two months. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for five months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.

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F 280	Continued From page 4  Review of a Complaint/Grievance Report dated 03/19/14 revealed on 03/17/14 the Ombudsman expressed concerns that residents on the Reflections Unit were not being properly supervised. The plan to resolve the grievance was to ensure the activities staff informed the nursing staff whenever they were leaving the unit.  Interview with the Ombudsman on 04/03/14 at 12:42 PM revealed he went into the Reflections Unit on 03/17/14 and witnessed two (2) residents, Resident #6 and Resident #7, in the dayroom, one sitting in a wheelchair, one standing up, who were pulling and tugging on each other, with one appearing upset and trying to get away from the other. The Ombudsman revealed no staff was present in the dayroom, so he left the dayroom and went to the nursing station to get a nurse, and upon their return the residents were separated.  Interview with LPN #5 on 04/08/14 at 2:47 PM revealed he had to leave the unit on 03/17/14 to get oxygen for a resident, and when he came back, the Ombudsman told him what had transpired between Resident #7 and Resident #6.  Review of Resident #7's care plan revealed "New order, 03/18/14", with no indication what the new order was. Review of Resident #7's orders revealed an order for fifteen (15) minute checks was initiated on 03/18/14 as a result of the incident on 03/17/14,; however, there was no documented evidence the care plan was revised to reflect this intervention.  Interview with the Director of Nursing (DON) on 04/08/14 at 1:15 PM revealed Resident #7's care	F 280			

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F 280	Continued From page 5 plan should have indicated fifteen (15) minute checks were initiated instead of requiring anyone reviewing the care plan to go to the chart looking for a doctor's order.	F 280			
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 observation, interview and record review it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for four (4) of ten (10) sampled residents, Residents #4, #5, #6 and #7. The facility failed to provide adequate supervision consistent with each resident's needs when Resident #4 got up from his/her wheelchair and took several steps unassisted prior to staff noticing and intervening to protect him/her on 03/04/14. Resident #7 was discovered unsupervised by the Ombudsman in the dayroom of the Reflections Unit on 03/17/19 in a physical altercation with Resident #6. Observations of Resident #5 revealed repeated self-rising behavior and constant supervision requirements. Additionally, interviews indicated frequent instances in which residents on the Reflections Unit were not sufficiently supervised to ensure a safe environment.	F 323	F323  1. On 04/04/2014 the Reflections Unit was assessed by VP of Operations, Regional Nurse Consultants, Administrator, DON, Plant Operations, and Environmental Director to ensure the environment was safe and Residents #4, #5, #6, and #7 was properly supervised. The environment was found to be safe and proper supervision was being provided.  2. On 04/04/2014 the Reflections Unit was assessed by VP of Operations, Regional Nurse Consultants, Administrator, DON, Plant	5/10/14	

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F 323 Continued From page 6

The findings include:

1. Review of Resident #4 's medical record revealed he/she was admitted to the facility on 02/28/14 with diagnoses to include Dementia NOS With Behavioral Disturbance, Difficulty in Walking, and Muscle Weakness (General). The facility assessed Resident #4, in an Admission Minimum Data Set (MDS) dated 03/07/14, as severely cognitively impaired. Further, the facility assessed Resident #4 as exhibiting physical behaviors directed towards others one (1) to three (3) days, verbal behaviors directed towards others four (4) to six (6) days, and other behaviors not directed towards others for one (1) to three (3) days of the seven (7) day look back period, which put Resident #4 and others at risk and disrupted care or the environment. The facility further assessed Resident #4 as an assist of two (2) with both transfers and ambulation.

Review of a nursing assessment dated 03/08/14 revealed Resident #4 experienced a fall in the dayroom after standing from his/her wheelchair at 6:15 PM. Resident #4 suffered no injury, and a pressure alarm was added to his/her wheelchair at that time.

Interview with State Registered Nursing Assistant (SRNA) #1 on 04/02/14 at 2:00 PM revealed Resident #4 made frequent attempts to arise from his/her wheelchair, and SRNA #1 had been watching him/her on 03/04/14. SRNA #1 went on to reveal she had to go off the unit to recover a hair dryer, as SRNA #2 had completed a shower and needed it for a resident. SRNA #1 revealed when she returned to the unit, Resident #4 was three (3) or four (4) feet away from his/her

F 323

Operations, and Environmental Director to ensure the environment was safe for all residents residing on the Reflections Unit and that the residents were properly supervised. Daily from 04/04/2014 thru 04/08/2014 environmental safety rounds and adequate supervision rounds were completed by environmental services department, nursing staff, DON, SDC, MDS, Nursing Supervisor, Administrator, Admissions Coordinator, QOL, HR, Medical Records, Central Supply Coordinator, Chaplain, or Regional Management team to ensure adequate supervision was being provided and that resident areas were free from environmental hazards to prevent accidents. The environment was found to be safe and proper supervision was being provided. A 100 percent review of all accidents and incidents for the past 90 days was completed to ensure that immediate intervention implementation was care planned and communicated to all staff. The review was initiated on 4/04/2014 and was completed on 4/11/14 by DON, Regional Nurse Consultants, ADON, Restorative Nurse, Unit

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F 323 Continued From page 7

wheelchair, and although the nurse was present she was turned around giving medications and didn't see Resident #4 until SRNA #1 called out in a panic to Resident #4. SRNA #1 revealed she got to Resident #4 and was able to assist him/her to his/her seat. Further interview with SRNA #1 revealed Resident #4 cursed, swung his/her fists at people, and took his/her clothing off, all behaviors requiring extensive staff supervision and redirection.

Interview with SRNA #4 on 04/02/14 at 3:10 PM revealed Resident #4 had been aggressive to workers, and had struck a nurse in the nose one night. Further, SRNA #4 described Resident #4 as "fidgety", and went on to reveal he/she frequently stood up from his/her wheelchair, then sat back down, then stood back up, and could be aggressive when attempts were made to redirect him/her.

Interview with SRNA #2 on 04/03/14 at 1:02 PM revealed Resident #4 frequently attempted to get up from or walking away from his/her wheelchair, which required extensive staff supervision to ensure his/her safety. SRNA #2 went on to express, although staff was usually present, she felt accidents could be prevented if someone was available supervising the residents in the dayroom all the time.

2. Review of Resident #7's medical record revealed Resident #7 was admitted to the facility on 01/07/14 with diagnoses which included Alzheimer's Disease, Dementia NOS With Behavioral Disturbance, and Psychosis NOS. The facility assessed Resident #7, in a Significant Change Minimum Data Set (MDS) dated 02/21/14, as severely cognitively impaired with a

F 323 Managers, MDS, SDC, and Evening Shift Supervisor.

3. On 04/04/2014 education was initiated by Regional Nurse Consultant and Staff Development Coordinator to all staff that was on shift related to proper supervision for all residents, fall policy, accident prevention, including CNA to licensed nurse communication to ensure that proper supervision was being provided for residents in the day room on the Reflections Unit. Education was continued for all staff by the SDC, ADON, Weekend Supervisor, and Evening Shift Supervisor and was completed by 04/11/2014.

On 04/04/2014, the supervision of the Reflections Unit was assessed by the ADON, DON, Unit Manager, and the Restorative Nurse by reviewing the Residents' MDS and care plans. The decision was made to rearrange the staffing to include a SRNA for 12 hours a day to supervise the residents in the day room and one additional SRNA was added to the 11pm

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F 323	Continued From page 8 Brief Interview for Mental Status (BIMS) score of 04/15, indicating severe cognitive impairment. Further, the facility assessed Resident #7 as having delusions and exhibiting physical behavior directed towards others one (1) to three (3) days of the seven (7) day look back period for the assessment which put the resident and others at significant risk for physical injury and disrupted care or the living environment.  Review of a Complaint/Grievance Report dated 03/19/14 revealed on 03/17/14 the Ombudsman expressed concerns that residents on the Reflections Unit were not being properly supervised. The plan to resolve the grievance was to ensure the activities staff informed the nursing staff whenever they were leaving the unit.  Interview with the Ombudsman on 04/03/14 at 12:42 PM revealed he went into the Reflections Unit on 03/17/14 and witnessed Resident #6 and Resident #7 in the dayroom, one sitting in a wheelchair, one standing up, who were pulling and tugging on each other, with Resident #7 appearing upset and trying to get away. The Ombudsman revealed there was no staff in the dayroom at the time of the altercation he witnessed. He stated had to leave the dayroom to go to the nursing station to get a nurse.  Interview with Licensed Practical Nurse (LPN) #5 on 04/08/14 at 2:47 PM revealed he had to leave the unit on 03/17/14 to get oxygen for a resident, and when he came back, the Ombudsman told him what had transpired between Resident #7 and Resident #6. LPN #5 revealed he immediately assessed both residents and interviewed them, both denying any pain, neither recalling the incident. LPN #5 went on to reveal	F 323	to 7am shift on the Reflections Unit.  DON, ADON, Unit Managers, and Rehab Service Manager will review all accidents and incidents daily Monday thru Friday during morning clinical meeting to ensure that immediate intervention implementation has been care planned and communicated to all staff.  4. Beginning on 04/04/2014 a daily observation of all areas accessible to residents was initiated by all department management staff including but not limited to the following: DON, Administrator, ADON, Nursing Supervisors, Business Office Manager, Human Resource Manager, Admissions Coordinator, Plant Operations, Environmental Director, Dietary Manager, SDC, Restorative Nurse, Social Service Directors, QOL Director, and Staffing Coordinator to ensure proper supervision was being provided and the environment is free from accident hazards as		

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F 323 Continued From page 9  
he reported the incident. LPN #5 revealed he was gone from the unit for ten (10) to fifteen (15) minutes, and there had been an SRNA in the dayroom when he left.

Interview with LPN #1 on 04/03/14 at 9:38 AM revealed a nurse or activities staff should have been in the dayroom depending on the time. LPN #1 further revealed if both nurse aides were in the shower room assisting a resident, they were responsible for letting the nurse know, so the nurse could provide supervision of the dayroom.

Interview with SRNA #4 on 04/03/14 at 4:35 PM revealed Resident #6 and Resident #7 were roommates, and Resident #6 had been known to lay in bed and yell, which caused Resident #7 to become agitated. SRNA #4 revealed she had witnessed Resident #7 threaten Resident #6 one night, saying " If you don't shut up, I'm going hit you", and had his/her fists balled up. SRNA #4 revealed she had never actually witnessed Resident #7 strike anyone, although he/she did pull her [SRNA #4's] hair on one occasion when she intervened between the resident and Unsampld Resident #C.

Interview with SRNA #5 on 04/03/14 at 5:01 PM confirmed Resident #6's yelling does irritate Resident #7, and although Resident #7 has not had any physical altercations with other residents, he/she had struck a nurse a couple of weeks ago. SRNA #5 stated it used to be safe for residents in the dayroom unsupervised, but with the changing resident population exhibiting more behavioral issues, it was not safe for them unsupervised now.

Interview with SRNA #2 on 04/03/14 at 1:02 PM

F 323 possible. If an issue is found, the issue is to be addressed and corrected immediately and if the issue is not able to be resolved immediately notification to Plant Operations, DON, or the Administrator is to be made immediately. This was provided by a department manager daily for the first week, then daily Monday thru Friday beginning on May 8, 2014, for two months, then 3 days a week for three weeks, then once weekly for two weeks. All accidents and incidents will be reviewed in the morning clinical meeting by the DON, ADON, Unit Managers, and Rehab Service Manager daily Monday thru Friday ongoing to ensure that immediate interventions implementation is care planned and communicated to all staff. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical

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F 323	Continued From page 10 revealed Resident #6 tended to bump into people a lot in his/her wheelchair, which aggravated some residents on the unit. SRNA #2 revealed Resident #7 could be aggressive, didn't like to be redirected, and sometimes when staff tried to redirect him/her he would shove or smack them. SRNA #2 revealed she hadn't seen Resident #7 display any aggression towards other residents and didn't think he/she would intentionally hurt anyone.  Interview with SRNA #1 on 04/03/14 at 1:40 PM revealed a second incident involving Resident #7 and Unsampled Resident #C. SRNA #1 revealed on 03/22/14 late evening while they were assisting other residents, she saw Resident #7 grab Unsampled Resident #C by the upper arms when both residents were attempting to enter a room that belonged to neither. Per SRNA #1, Unsampled Resident #C screamed, and when SRNA #1 intervened and asked, Resident #7 let him/her go.  Review of a nursing assessment dated 03/22/14 revealed the incident occurred at 8:00 PM, with Resident #7 reporting to staff Unsampled Resident #C stated he/she was going to bite Resident #7. Further review revealed both residents were assessed and there were no injuries.  Interview with the Director of Nursing (DON) on 04/03/14 at 3:36 PM revealed both aides were in the shower room at the time the incident occurred. She state the facility implemented a shower aide for the Reflections Unit so that both assigned aides would not be in the shower room at the same time to assist residents that required two (2) assist for showers.	F 323	Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.		

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F 323	<p>Continued From page 11</p> <p>Review of the SRNA Assignment sheets from 03/21/14, the date the shower aide was initiated, through 04/01/14, the day prior to the initiation of survey, revealed several instances in which a shower aide was either not assigned or was reassigned to replace missing staff. Shower aides were not available, per review, on the following dates and shifts: 03/22/14 on 3-11; 03/23/14 on 7-3 and 3-11; 03/28/14 on 7-3; 03/30/14 on 3-11; and 04/01/14 on 7-3 and 3-11.</p> <p>Interview with SRNA #1 on 04/07/14 at 2:17 PM revealed nursing aides told nursing staff "right from the beginning" that they needed more assistance on the Reflections Unit, particularly since the admission of Resident #5. SRNA #1 went on to reveal nursing aides had spoken with "probably about all of them [nurses]", and nursing staff had witnessed Resident #5's behaviors of attempting to exit his/her wheelchair. SRNA #1 went on to reveal Resident #5 required a staff member to be seated next to him/her at all times to help ensure his/her safety, otherwise he/she would likely fall.</p> <p>Interview with SRNA #7 on 04/04/14 at 12:40 PM revealed nursing aides had asked nursing staff to "call whoever they call" about getting assistance on the unit, but had been told "they" say "if we don't quit griping, they can move us off the unit". SRNA #7 revealed she didn't feel it safe for residents to be left alone in the dayroom, as they could get into an altercation, trip over a wheelchair, or any number of other things could occur which would jeopardize their safety. SRNA #7 went on to reveal when both aides need to be in back working with a resident, they try to get the nurse to keep an eye on residents in the</p>	F 323		
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F 323	<p>Continued From page 12</p> <p>dayroom, but some nurses very seldom stay with residents in the dayroom, and there are times no one is at the nursing station.</p> <p>3. Review of Resident #5's medical record revealed Resident #5 was admitted to the facility on 03/24/14 with diagnoses of Anxiety State NOS, Dementia With Behavioral Disturbance, and Psychosis NOS. Additionally, Resident #5 was identified on his/her Interim Plan of Care, dated 03/24/14, as a fall risk. Admission Nurse's Notes for 03/24/14 revealed Resident #5 was admitted with a self-releasing lap buddy and alarm to his/her wheelchair, and also revealed Resident #5 as attempting to stand without assistance, and being redirectable only for short periods of time.</p> <p>Observation of Resident #5 on 04/02/14 at 10:30 AM revealed Resident #5 kept attempting to rise up out of his/her wheelchair, setting off his/her pressure alarm, despite staff attempting to engage resident in activities. Activity Staff #1 attempted to engage Resident #5, mostly unsuccessfully, while also continuing her attempts to maintain the attention of other resident who had been participating in activities.</p> <p>Interview with Activities Staff #1 on 04/02/14 at 3:48 PM revealed the population admitted now consisted of residents with behavioral issues, which didn't mix well with the Alzheimer's dementia residents. Activities Staff #1 went on to reveal her job was to direct resident activities, although that morning and on multiple other occasions there had been no other staff in the dayroom to assist with residents not participating in activities.</p> <p>Interview with the Ombudsman on 04/03/14 at</p>	F 323		
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F 323 Continued From page 13

12:42 PM revealed he had been to the Reflections Unit dayroom on multiple occasions when there would be residents in the dayroom with no staff present. The Ombudsman went on to reveal he would sometimes have to wait ten (10) minutes before a staff member would arrive in the dayroom.

Interview with SRNA #2 on 04/03/14 at 1:02 PM revealed she had come into the dayroom on occasion and observed the Ombudsman sitting with residents while no other staff member were present. SRNA #2 also revealed she had entered the dayroom before when there would be residents present and no one supervising them. SRNA #2 stated they tried hard to keep watch on the dayroom, however sometimes what you thought would be a minute helping out on the hall turned out to be ten (10) minutes.

Interview with SRNA #8 on 04/04/14 at 2:27 PM revealed shower aides worked day shift, as she had not seen them on the Reflections Unit for second shift. SRNA #8 revealed some days not all resident showers are completed. SRNA #8 revealed she had worked with Resident #5 two or three times, and each time she had to take Resident #5 down the hall with her while providing care to other residents, never able to let Resident #5 out of her sight for fear Resident #5 would fall. SRNA #8 revealed the nurse in the dayroom helped, but when passing medications wasn't able to watch Resident #5 sufficiently to prevent accidents. SRNA #8 stated she didn't feel residents were safe on the Reflections Unit due to lack of staff.

Interview with LPN #2 on 04/02/14 at 5:00 PM revealed the nurse aides asked for her help on

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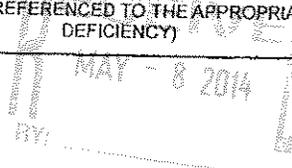
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F 323	<p>Continued From page 14</p> <p>the Reflections Unit, and sometimes she took it upon herself to try to help them. LPN #2 revealed her job was to concentrate on medications, but with two (2) aides she felt they needed another person to assist.</p> <p>Interview with Registered Nurse (RN) #2 on 04/07/14 at 3:05 PM revealed she did recall the nurse aides expressing to her it was difficult supervising Resident #5, and expressed the aides as well as herself did the best they could with the staff they had. RN #2 revealed they tried to have someone with Resident #5 at all times while he/she was awake, and did their best to keep him/her close to them at all times to prevent him/her from falling. RN #2 revealed when two (2) aides and a floor nurse were working, they did their best to keep residents safe.</p> <p>Interview with the Director of Nursing (DON) on 04/03/14 at 3:36 PM revealed her expectation was staff who was assigned to the Reflections Unit knew the dayroom needed to be monitored. The DON stated she couldn't answer how long residents would be safe without supervision, but stated the area shouldn't be left unmonitored for more than fifteen (15) minutes.</p>	F 323		
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N 000	INITIAL COMMENTS  A Complaint Investigation of ARO #KY00021487 was initiated on 04/02/14 and concluded on 04/08/14, with deficient practice cited.	N 000		
N 192	<p>902 KAR 20:300-7(4)(b)3. Section 7. Resident Assessment</p> <p>(4) Comprehensive care plans. (b) A comprehensive care plan shall be: 3. Periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This requirement is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure care plans were reviewed and revised after each incident for two (2) of ten (10) sampled residents (Residents #5 and #7). Resident #5 suffered a fall on 03/31/14, for which no intervention was documented on the Interim Care Plan. Resident #7 was placed on fifteen (15) minute checks after a resident to resident confrontation on 03/17/14, however, his/her care plan did not detail the fifteen (15) minute checks that were put into place following the confrontation.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Care Planning", dated December 2010 revealed the Plan of Care was to be individualized based on resident assessment, and staff was to document the plan of care, treatment and services. Further review revealed staff was to regularly review and revise the Plan of Care, treatment and services.</p> <p>1. Review of Resident #5's medical record</p>	N 192	<p>N 192</p> <p>1. On 04/09/2014 Resident #5 care plan was revised to reflect the intervention that was put in place after the fall on 03/30/2014, which included discontinuation of the tab alarm and a sensor pad alarm being put in place.</p> <p>On 04/09/2014, Resident #5 care plan was revised to reflect the immediate intervention that was implemented on 03/31/14, after a fall. The immediate intervention was communicated to staff by verbal communication and by placing the intervention on the CNA Care Plan. The immediate intervention included the staff being educated on providing activities of interest for Resident #5 to redirect Resident #5 from attempting to rise from chair without assistance and divert her anxious behavior.</p> <p>On 04/09/2014, Resident #7 Care Plan was revised to reflect</p>	5/10/14

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

*Silena Hudson*

TITLE

*Administrator*

(X6) DATE

*5/8/14*

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N 192	<p>Continued From page 1</p> <p>revealed Resident #5 was admitted to the facility on 03/24/14 with diagnoses of Anxiety State NOS, Dementia With Behavioral Disturbance, and Psychosis NOS. Additionally, Resident #5 was identified on his/her Interim Plan of Care, dated 03/24/14, as a fall risk. Admission Nurse's Notes for 03/24/14 revealed Resident #5 was admitted with a self-releasing lap buddy and alarm to his/her wheelchair, and also revealed Resident #5 was attempting to stand without assistance and as being redirectable only for short periods of time.</p> <p>Observation of Resident #5 on 04/02/14 at 10:30 AM revealed Resident #5 kept attempting to rise up from his/her wheelchair, setting off his/her pressure alarm, despite therapy staff attempting to engage resident in mnemonic activities. After approximately ten (10) minutes of failed attempts to engage Resident #5 in activity, therapy staff wheeled Resident #5 over to the central area of the dayroom where other residents were engaged in activities. Resident #5 continued to attempt to rise, while repetitively stating "Jesus loves me" or at times "Jesus help me".</p> <p>Review of Resident #5's nursing assessments revealed he/she experienced three (3) falls from his/her date of admission, 03/24/14 through 04/02/14. Resident #5's first fall was on 03/25/14 at 12:45 PM, at which time Resident #5 was found on the floor at bedside with no injury and no witness to the fall. Review of the Interim Plan of Care revealed a bed alarm was placed on Resident #5's bed, and a referral to physical therapy and occupational therapy was made. Further review of the Interim Care Plan revealed anti-tippers were added to Resident #5's wheelchair on 03/27/14. Resident #5 experienced a second fall on 03/30/14 at 3:45</p>	N 192	<p>the Q15 minute checks that were initiated on 03/18/2014.</p> <p>2. On 04/08/2014 a complete review of all care plans was initiated by Regional Nurse Consultants, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, Unit Managers, Evening Shift Supervisor, and Restorative Nurse and was completed on 04/11/2014. The review was to ensure that all care plans were implemented and revised according to any change in condition noted and each Resident's needs, which included appropriate interventions for all accidents and incidents for the past 90 days.</p> <p>3. All licensed nursing staff was educated on 4/10/14 related to implementation of immediate interventions for all accidents and incidents and revision of resident care plans. All nursing staff was educated on 4/10/14 related to the care planning process including updating the</p>	

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N 192	<p>Continued From page 2</p> <p>PM, at which time Resident #5 was again found at bedside without injury. The nursing assessment revealed a sensor alarm replaced the tab alarm that had been on Resident #5's bed at that time, although review of the Interim Care Plan revealed no change, and the Interim Care Plan was not updated after this fall. Resident #5 experienced a third fall on 03/31/14 at 11:30 AM in the dayroom, which was witnessed by staff, at which time Resident #5 suffered a laceration to his/her forehead, to the bridge of the nose, and a skin tear to his/her left wrist. Further review of Resident #5's medical record revealed he/she received sutures for his/her lacerations in the local emergency room and was returned to the facility. The nursing assessment revealed no new nursing interventions were added, and review of the Interim Care Plan revealed no changes following the fall.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 04/03/14 at 9:38 AM revealed following Resident #5's falls on 03/30/14 and 03/31/14, the facility put in a request for another physical therapy screen, which was standard practice when a resident had a fall. LPN #1 revealed the request for physical therapy screen should have been reflected on the care plan, and that any staff could have updated the interim care plan. LPN #1 revealed the nurse that put in the request should have updated the care plan.</p> <p>Interview with Registered Nurse (RN) #2 on 04/06/14 at 3:05 PM revealed on 03/31/14 after Resident #5's third fall, she made sure to ask the Director of Nursing (DON) if there was anything else they could be doing to help Resident #5, and shared the DON said to make sure to do more activities with Resident #5 and get him/her more involved, information which RN #2 stated she</p>	N 192	<p>CNA's care plan to reflect any revisions from a change in condition. All orders will be reviewed Monday thru Friday in the morning clinical meetings to ensure proper care planning of any change in condition to reflect the resident's needs and proper interventions are implemented and care planned for all accidents and incidents. All accidents and incidents are then brought to the morning stand up meeting Monday thru Friday to review the intervention implementation, effectiveness, and care planning.</p> <p>4. The DON, ADON, or Unit Managers will review all care plans to ensure any change in condition is care planned or revised as needed daily, Monday thru Friday for two weeks, and the process will be completed on Saturday and Sunday by the weekend supervisor beginning on May 10, 2014. Then, the DON, ADON, or Unit Managers will review 5 random Resident care plans from all units weekly for four weeks, then 3 per week for</p>	

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N 192	<p>Continued From page 3</p> <p>shared with the State Registered Nursing Assistants (SRNAs). RN #2 revealed she didn't know for certain if the care plan was re-evaluated but said it should have been revised.</p> <p>2. Review of Resident #7's medical record revealed Resident #7 was admitted to the facility on 01/07/14 with diagnoses which included Alzheimer's Disease, Dementia NOS With Behavioral Disturbance, and Psychosis NOS. The facility assessed Resident #7, in a Significant Change Minimum Data Set (MDS) dated 02/21/14, as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 04/15, indicating severe cognitive impairment. Further, the facility assessed Resident #7 as having delusions and exhibiting physical behavior directed towards others.</p> <p>Review of a Complaint/Grievance Report dated 03/19/14 revealed on 03/17/14 the Ombudsman expressed concerns that residents on the Reflections Unit were not being properly supervised. The plan to resolve the grievance was to ensure the activities staff informed the nursing staff whenever they were leaving the unit.</p> <p>Interview with the Ombudsman on 04/03/14 at 12:42 PM revealed he went into the Reflections Unit on 03/17/14 and witnessed two (2) residents, Resident #6 and Resident #7, in the dayroom, one sitting in a wheelchair, one standing up, who were pulling and tugging on each other, with one appearing upset and trying to get away from the other. The Ombudsman revealed no staff was present in the dayroom, so he left the dayroom and went to the nursing station to get a nurse, and upon their return the residents were separated.</p>	N 192	<p>four weeks, and then 2 monthly for two months. The ongoing process will be discussed in the Quality Assurance committee meeting monthly for five months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.</p>		

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N 192	Continued From page 4  Interview with LPN #5 on 04/08/14 at 2:47 PM revealed he had to leave the unit on 03/17/14 to get oxygen for a resident, and when he came back, the Ombudsman told him what had transpired between Resident #7 and Resident #6.  Review of Resident #7's care plan revealed "New order, 03/18/14", with no indication what the new order was. Review of Resident #7's orders revealed an order for fifteen (15) minute checks was initiated on 03/18/14 as a result of the incident on 03/17/14,; however, there was no documented evidence the care plan was revised to reflect this intervention.  Interview with the Director of Nursing (DON) on 04/08/14 at 1:15 PM revealed Resident #7's care plan should have indicated fifteen (15) minute checks were initiated instead of requiring anyone reviewing the care plan to go to the chart looking for a doctor's order.	N 192		
N 220	902 KAR 20:300-8(7)(b) Section 8. Quality of Care  (7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents.  This requirement is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for four (4) of ten	N 220	N 220  1. On 04/04/2014 the Reflections Unit was assessed by VP of Operations, Regional Nurse Consultants, Administrator, DON, Plant Operations, and Environmental Director to ensure the environment was safe and Residents #4, #5, #6, and #7 was properly supervised. The environment was found to be	5/10/14

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**FOUNTAIN CIRCLE CARE & REHABILITATION**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**200 GLENWAY ROAD  
WINCHESTER, KY 40391**

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N 220	<p>Continued From page 5</p> <p>(10) sampled residents, Residents #4, #5, #6 and #7. The facility failed to provide adequate supervision consistent with each resident's needs when Resident #4 got up from his/her wheelchair and took several steps unassisted prior to staff noticing and intervening to protect him/her on 03/04/14. Resident #7 was discovered unsupervised by the Ombudsman in the dayroom of the Reflections Unit on 03/17/19 in a physical altercation with Resident #6. Observations of Resident #5 revealed repeated self-rising behavior and constant supervision requirements. Additionally, interviews indicated frequent instances in which residents on the Reflections Unit were not sufficiently supervised to ensure a safe environment.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of Resident #4 's medical record revealed he/she was admitted to the facility on 02/28/14 with diagnoses to include Dementia NOS With Behavioral Disturbance, Difficulty in Walking, and Muscle Weakness (General). The facility assessed Resident #4, in an Admission Minimum Data Set (MDS) dated 03/07/14, as severely cognitively impaired. Further, the facility assessed Resident #4 as exhibiting physical behaviors directed towards others one (1) to three (3) days, verbal behaviors directed towards others four (4) to six (6) days, and other behaviors not directed towards others for one (1) to three (3) days of the seven (7) day look back period, which put Resident #4 and others at risk and disrupted care or the environment. The facility further assessed Resident #4 as an assist of two (2) with both transfers and ambulation.</li> </ol> <p>Review of a nursing assessment dated 03/08/14 revealed Resident #4 experienced a fall in the</p>	N 220	<p>safe and proper supervision was being provided.</p> <p>2. On 04/04/2014 the Reflections Unit was assessed by VP of Operations, Regional Nurse Consultants, Administrator, DON, Plant Operations, and Environmental Director to ensure the environment was safe for all residents residing on the Reflections Unit and that the residents were properly supervised. Daily from 04/04/2014 thru 04/08/2014 environmental safety rounds and adequate supervision rounds were completed by environmental services department, nursing staff, DON, SDC, MDS, Nursing Supervisor, Administrator, Admissions Coordinator, QOL, HR, Medical Records, Central Supply Coordinator, Chaplain, or Regional Management team to ensure adequate supervision was being provided and that resident areas were free from environmental hazards to prevent accidents. The environment was found to be safe and proper supervision was being provided. A 100 percent review of all accidents and incidents for the past 90 days was completed to ensure that immediate intervention</p>	

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N 220	<p>Continued From page 6</p> <p>dayroom after standing from his/her wheelchair at 6:15 PM. Resident #4 suffered no injury, and a pressure alarm was added to his/her wheelchair at that time.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 04/02/14 at 2:00 PM revealed Resident #4 made frequent attempts to arise from his/her wheelchair, and SRNA #1 had been watching him/her on 03/04/14. SRNA #1 went on to reveal she had to go off the unit to recover a hair dryer, as SRNA #2 had completed a shower and needed it for a resident. SRNA #1 revealed when she returned to the unit, Resident #4 was three (3) or four (4) feet away from his/her wheelchair, and although the nurse was present she was turned around giving medications and didn't see Resident #4 until SRNA #1 called out in a panic to Resident #4. SRNA #1 revealed she got to Resident #4 and was able to assist him/her to his/her seat. Further interview with SRNA #1 revealed Resident #4 cursed, swung his/her fists at people, and took his/her clothing off, all behaviors requiring extensive staff supervision and redirection.</p> <p>Interview with SRNA #4 on 04/02/14 at 3:10 PM revealed Resident #4 had been aggressive to workers, and had struck a nurse in the nose one night. Further, SRNA #4 described Resident #4 as "fidgety", and went on to reveal he/she frequently stood up from his/her wheelchair, then sat back down, then stood back up, and could be aggressive when attempts were made to redirect him/her.</p> <p>Interview with SRNA #2 on 04/03/14 at 1:02 PM revealed Resident #4 frequently attempted to get up from or walking away from his/her wheelchair, which required extensive staff supervision to</p>	N 220	<p>implementation was care planned and communicated to all staff. The review was initiated on 4/04/2014 and was completed on 4/11/14 by DON, Regional Nurse Consultants, ADON, Restorative Nurse, Unit Managers, MDS, SDC, and Evening Shift Supervisor.</p> <p>3. On 04/04/2014 education was initiated by Regional Nurse Consultant and Staff Development Coordinator to all staff that was on shift related to proper supervision for all residents, fall policy, accident prevention, including CNA to licensed nurse communication to ensure that proper supervision was being provided for residents in the day room on the Reflections Unit. Education was continued for all staff by the SDC, ADON, Weekend Supervisor, and Evening Shift Supervisor and was completed by 04/11/2014.</p> <p>On 04/04/2014, the supervision of the Reflections Unit was assessed by the ADON, DON, Unit Manager, and the Restorative Nurse by reviewing the Residents' MDS and care</p>	

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N 220	<p>Continued From page 7</p> <p>ensure his/her safety. SRNA #2 went on to express, although staff was usually present, she felt accidents could be prevented if someone was available supervising the residents in the dayroom all the time.</p> <p>2. Review of Resident #7's medical record revealed Resident #7 was admitted to the facility on 01/07/14 with diagnoses which included Alzheimer's Disease, Dementia NOS With Behavioral Disturbance, and Psychosis NOS. The facility assessed Resident #7, in a Significant Change Minimum Data Set (MDS) dated 02/21/14, as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 04/15, indicating severe cognitive impairment. Further, the facility assessed Resident #7 as having delusions and exhibiting physical behavior directed towards others one (1) to three (3) days of the seven (7) day look back period for the assessment which put the resident and others at significant risk for physical injury and disrupted care or the living environment.</p> <p>Review of a Complaint/Grievance Report dated 03/19/14 revealed on 03/17/14 the Ombudsman expressed concerns that residents on the Reflections Unit were not being properly supervised. The plan to resolve the grievance was to ensure the activities staff informed the nursing staff whenever they were leaving the unit.</p> <p>Interview with the Ombudsman on 04/03/14 at 12:42 PM revealed he went into the Reflections Unit on 03/17/14 and witnessed Resident #6 and Resident #7 in the dayroom, one sitting in a wheelchair, one standing up, who were pulling and tugging on each other, with Resident #7 appearing upset and trying to get away. The Ombudsman revealed there was no staff in the</p>	N 220	<p>plans. The decision was made to rearrange the staffing to include a SRNA for 12 hours a day to supervise the residents in the day room and one additional SRNA was added to the 11pm to 7am shift on the Reflections Unit.</p> <p>DON, ADON, Unit Managers, and Rehab Service Manager will review all accidents and incidents daily Monday thru Friday during morning clinical meeting to ensure that immediate intervention implementation has been care planned and communicated to all staff.</p> <p>4. Beginning on 04/04/2014 a daily observation of all areas accessible to residents was initiated by all department management staff including but not limited to the following: DON, Administrator, ADON, Nursing Supervisors, Business Office Manager, Human Resource Manager, Admissions Coordinator, Plant Operations, Environmental Director, Dietary Manager, SDC, Restorative Nurse, Social</p>	
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N 220	<p>Continued From page 8</p> <p>dayroom at the time of the altercation he witnessed. He stated had to leave the dayroom to go to the nursing station to get a nurse.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 04/08/14 at 2:47 PM revealed he had to leave the unit on 03/17/14 to get oxygen for a resident, and when he came back, the Ombudsman told him what had transpired between Resident #7 and Resident #6. LPN #5 revealed he immediately assessed both residents and interviewed them, both denying any pain, neither recalling the incident. LPN #5 went on to reveal he reported the incident. LPN #5 revealed he was gone from the unit for ten (10) to fifteen (15) minutes, and there had been an SRNA in the dayroom when he left.</p> <p>Interview with LPN #1 on 04/03/14 at 9:38 AM revealed a nurse or activities staff should have been in the dayroom depending on the time. LPN #1 further revealed if both nurse aides were in the shower room assisting a resident, they were responsible for letting the nurse know, so the nurse could provide supervision of the dayroom.</p> <p>Interview with SRNA #4 on 04/03/14 at 4:35 PM revealed Resident #6 and Resident #7 were roommates, and Resident #6 had been known to lay in bed and yell, which caused Resident #7 to become agitated. SRNA #4 revealed she had witnessed Resident #7 threaten Resident #6 one night, saying " If you don't shut up, I'm going hit you", and had his/her fists balled up. SRNA #4 revealed she had never actually witnessed Resident #7 strike anyone, although he/she did pull her [SRNA #4's] hair on one occasion when she intervened between the resident and Unsampld Resident #C.</p>	N 220	<p>Service Directors, QOL Director, and Staffing Coordinator to ensure proper supervision was being provided and the environment is free from accident hazards as possible. If an issue is found, the issue is to be addressed and corrected immediately and if the issue is not able to be resolved immediately notification to Plant Operations, DON, or the Administrator is to be made immediately. This was provided by a department manager daily for the first week, then daily Monday thru Friday beginning on May 8, 2014, for two months, then 3 days a week for three weeks, then once weekly for two weeks. All accidents and incidents will be reviewed in the morning clinical meeting by the DON, ADON, Unit Managers, and Rehab Service Manager daily Monday thru Friday ongoing to ensure that immediate interventions implementation is care planned and communicated to all staff. The ongoing process will be discussed in the Quality Assurance committee meeting</p>	

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N 220	<p>Continued From page 9</p> <p>Interview with SRNA #5 on 04/03/14 at 5:01 PM confirmed Resident #6's yelling does irritate Resident #7, and although Resident #7 has not had any physical altercations with other residents, he/she had struck a nurse a couple of weeks ago. SRNA #5 stated it used to be safe for residents in the dayroom unsupervised, but with the changing resident population exhibiting more behavioral issues, it was not safe for them unsupervised now.</p> <p>Interview with SRNA #2 on 04/03/14 at 1:02 PM revealed Resident #6 tended to bump into people a lot in his/her wheelchair, which aggravated some residents on the unit. SRNA #2 revealed Resident #7 could be aggressive, didn't like to be redirected, and sometimes when staff tried to redirect him/her he would shove or smack them. SRNA #2 revealed she hadn't seen Resident #7 display any aggression towards other residents and didn't think he/she would intentionally hurt anyone.</p> <p>Interview with SRNA #1 on 04/03/14 at 1:40 PM revealed a second incident involving Resident #7 and Unsampled Resident #C. SRNA #1 revealed on 03/22/14 late evening while they were assisting other residents, she saw Resident #7 grab Unsampled Resident #C by the upper arms when both residents were attempting to enter a room that belonged to neither. Per SRNA #1, Unsampled Resident #C screamed, and when SRNA #1 intervened and asked, Resident #7 let him/her go.</p> <p>Review of a nursing assessment dated 03/22/14 revealed the incident occurred at 8:00 PM, with Resident #7 reporting to staff Unsampled Resident #C stated he/she was going to bite Resident #7. Further review revealed both</p>	N 220	<p>monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.</p>	

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N 220	Continued From page 10  residents were assessed and there were no injuries.  Interview with the Director of Nursing (DON) on 04/03/14 at 3:36 PM revealed both aides were in the shower room at the time the incident occurred. She state the facility implemented a shower aide for the Reflections Unit so that both assigned aides would not be in the shower room at the same time to assist residents that required two (2) assist for showers.  Review of the SRNA Assignment sheets from 03/21/14, the date the shower aide was initiated, through 04/01/14, the day prior to the initiation of survey, revealed several instances in which a shower aide was either not assigned or was reassigned to replace missing staff. Shower aides were not available, per review, on the following dates and shifts: 03/22/14 on 3-11; 03/23/14 on 7-3 and 3-11; 03/28/14 on 7-3; 03/30/14 on 3-11; and 04/01/14 on 7-3 and 3-11.  Interview with SRNA #1 on 04/07/14 at 2:17 PM revealed nursing aides told nursing staff "right from the beginning" that they needed more assistance on the Reflections Unit, particularly since the admission of Resident #5. SRNA #1 went on to reveal nursing aides had spoken with "probably about all of them [nurses]", and nursing staff had witnessed Resident #5's behaviors of attempting to exit his/her wheelchair. SRNA #1 went on to reveal Resident #5 required a staff member to be seated next to him/her at all times to help ensure his/her safety, otherwise he/she would likely fall.  Interview with SRNA #7 on 04/04/14 at 12:40 PM revealed nursing aides had asked nursing staff to "call whoever they call" about getting assistance	N 220		

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N 220	<p>Continued From page 11</p> <p>on the unit, but had been told "they" say "if we don't quit griping, they can move us off the unit". SRNA #7 revealed she didn't feel it safe for residents to be left alone in the dayroom, as they could get into an altercation, trip over a wheelchair, or any number of other things could occur which would jeopardize their safety. SRNA #7 went on to reveal when both aides need to be in back working with a resident, they try to get the nurse to keep an eye on residents in the dayroom, but some nurses very seldom stay with residents in the dayroom, and there are times no one is at the nursing station.</p> <p>3. Review of Resident #5's medical record revealed Resident #5 was admitted to the facility on 03/24/14 with diagnoses of Anxiety State NOS, Dementia With Behavioral Disturbance, and Psychosis NOS. Additionally, Resident #5 was identified on his/her Interim Plan of Care, dated 03/24/14, as a fall risk. Admission Nurse's Notes for 03/24/14 revealed Resident #5 was admitted with a self-releasing lap buddy and alarm to his/her wheelchair, and also revealed Resident #5 as attempting to stand without assistance, and being redirectable only for short periods of time.</p> <p>Observation of Resident #5 on 04/02/14 at 10:30 AM revealed Resident #5 kept attempting to rise up out of his/her wheelchair, setting off his/her pressure alarm, despite staff attempting to engage resident in activities. Activity Staff #1 attempted to engage Resident #5, mostly unsuccessfully, while also continuing her attempts to maintain the attention of other resident who had been participating in activities.</p> <p>Interview with Activities Staff #1 on 04/02/14 at 3:48 PM revealed the population admitted now consisted of residents with behavioral issues,</p>	N 220		

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N 220	<p>Continued From page 12</p> <p>which didn't mix well with the Alzheimer's dementia residents. Activities Staff #1 went on to reveal her job was to direct resident activities, although that morning and on multiple other occasions there had been no other staff in the dayroom to assist with residents not participating in activities.</p> <p>Interview with the Ombudsman on 04/03/14 at 12:42 PM revealed he had been to the Reflections Unit dayroom on multiple occasions when there would be residents in the dayroom with no staff present. The Ombudsman went on to reveal he would sometimes have to wait ten (10) minutes before a staff member would arrive in the dayroom.</p> <p>Interview with SRNA #2 on 04/03/14 at 1:02 PM revealed she had come into the dayroom on occasion and observed the Ombudsman sitting with residents while no other staff member were present. SRNA #2 also revealed she had entered the dayroom before when there would be residents present and no one supervising them. SRNA #2 stated they tried hard to keep watch on the dayroom, however sometimes what you thought would be a minute helping out on the hall turned out to be ten (10) minutes.</p> <p>Interview with SRNA #8 on 04/04/14 at 2:27 PM revealed shower aides worked day shift, as she had not seen them on the Reflections Unit for second shift. SRNA #8 revealed some days not all resident showers are completed. SRNA #8 revealed she had worked with Resident #5 two or three times, and each time she had to take Resident #5 down the hall with her while providing care to other residents, never able to let Resident #5 out of her sight for fear Resident #5 would fall. SRNA #8 revealed the nurse in the dayroom</p>	N 220		

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helped, but when passing medications wasn't able to watch Resident #5 sufficiently to prevent accidents. SRNA #8 stated she didn't feel residents were safe on the Reflections Unit due to lack of staff.

Interview with LPN #2 on 04/02/14 at 5:00 PM revealed the nurse aides asked for her help on the Reflections Unit, and sometimes she took it upon herself to try to help them. LPN #2 revealed her job was to concentrate on medications, but with two (2) aides she felt they needed another person to assist.

Interview with Registered Nurse (RN) #2 on 04/07/14 at 3:05 PM revealed she did recall the nurse aides expressing to her it was difficult supervising Resident #5, and expressed the aides as well as herself did the best they could with the staff they had. RN #2 revealed they tried to have someone with Resident #5 at all times while he/she was awake, and did their best to keep him/her close to them at all times to prevent him/her from falling. RN #2 revealed when two (2) aides and a floor nurse were working, they did their best to keep residents safe.

Interview with the Director of Nursing (DON) on 04/03/14 at 3:36 PM revealed her expectation was staff who was assigned to the Reflections Unit knew the dayroom needed to be monitored. The DON stated she couldn't answer how long residents would be safe without supervision, but stated the area shouldn't be left unmonitored for more than fifteen (15) minutes.

N 220