

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

PRINTED: 01/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/30/2015
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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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	<p><b>INITIAL COMMENTS</b></p> <p>A Revisit/Recertification/Extended/Abbreviated Survey was initiated on 12/15/15 and concluded on 12/30/15. The revisit to the abbreviated survey conducted on 10/29/15 determined the tags cited under 42 CFR 483.15 Quality of Life (F241) and 42 CFR 483.35 Dietary Services (F362) had been corrected. Complaints KY24147 and KY24163 were investigated in conjunction with the Recertification Survey. The Division of Health Care unsubstantiated the allegation for complaint KY24147 and substantiated complaint KY24163 with Immediate Jeopardy identified on 12/18/15 and determined to exist on 12/16/15 at 42 CFR 483.20 Resident Assessment (F282 at S/S of "J") and 42 CFR 483.25 Quality of Care (F323 at S/S of "J"), with Substandard Quality of Care identified in 42 CFR 493.25 Quality of Care (F323) The facility was notified of the Immediate Jeopardy on 12/18/15.</p> <p>The facility assessed Resident #29 as an elopement risk due to the resident's history of wandering tendencies and current behaviors of wandering. The facility initiated the Comprehensive Care Plan to address the resident's risk for elopement with a goal the resident would not leave the facility without an escort. On 12/16/15, at approximately 5:35 AM, Resident #29 exited the facility without staff knowledge. The resident was found off the facility's grounds, walking in the middle of an unlit, two lane, busy road with no sidewalks and using a rolling walker. There were two cars stopped in opposite directions, blinking their lights to avoid hitting the resident. The resident was returned to the facility by staff at 6:00 AM without harm. The resident's Wander Guard device activated the</p>	F 000	<p>The Regis Woods Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed because it is required by federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Christopher Embert, NHA</i>	TITLE <i>X Administrator</i>	(X8) DATE <i>X 2-5-16</i>
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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.

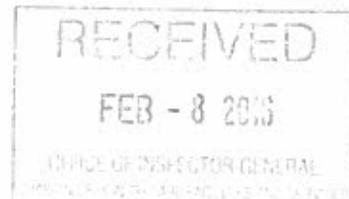
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F 000	<p>Continued From page 1</p> <p>door's alarm when the resident walked back into the building. The facility's investigation determined the door alarm was activated and staff failed to respond according to facility policy. The staff failed to search the area (including looking outside) where the door alarm was activated and failed to ensure all residents were present.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 12/23/15 which alleged removal of the Immediate Jeopardy on 12/22/15. The State Survey Agency verified Immediate Jeopardy was removed on 12/22/15 as alleged, prior to exit on 12/30/15. The Scope and Severity was lowered to a "D" at 42 CFR 483.20 (282) and 42 CFR 483.25 (F323) while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>Additional deficiencies were cited as a result of the Recertification Survey at 42 CFR 483.10 Resident Rights (F164), (F167), and (F174) at Scope and Severity of a "D"; 42 CFR 483.15 Quality of Life (F246) (F248) at a Scope and Severity of a "D" and (F253) at a Scope and Severity of an "E"; at 42 CFR 483.20 Resident Assessment (F274) and (F281) at a Scope and Severity of a "D"; at 42 CFR 483.25 Quality of Care (F309) (F312) and (F332) at a scope and severity of a "D"; at 42 CFR 483.35 Dietary Services (F364) and (F371) at Scope and Severity of an "F"; at 42 CFR 483.60 Pharmacy Services (F431) at a Scope and Severity of a "D"; at 42 CFR 483.65 Infection Control (F441) at a Scope and Severity of an "E"; and 42 CFR 483.75 Administration (F520) at a Scope and Severity of an "F".</p>	F 000	INTENTIONALLY LEFT BLANK	



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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution, or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide privacy for one (1) of thirty-seven (37) sampled residents, Resident #7. Certified Nursing Assistant (CNA) #1 obtained the</p>	F 164	<p>F 164</p> <ol style="list-style-type: none"> <li>The Social Worker completed a re-assessment of resident #7 on December 23, 2015 to ensure the resident has not experienced a decline in mood from the lack of visual privacy provided the resident with no areas of concern identified. Certified Nursing Assistant (CNA) #1 was re-educated by Unit Manager on December 23, 2015 regarding need to provide visual privacy by closing resident room door and privacy curtain when providing resident #7 care.</li> <li>All residents of the facility have the potential to be affected. The facility Unit Managers completed visual observations over all three shifts on December 23, 2015 to determine residents were provided privacy during care including closing resident room door and privacy curtain. Areas of concern were corrected upon discovery.</li> </ol>	2/13/16
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F 164	<p>Continued From page 3</p> <p>resident's weight using a Hoyer lift scale in the resident's room without providing visual privacy to the resident.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Treatment: Considerate and Respectful, dated 09/01/13, revealed the staff would maintain the resident's privacy of body and would close doors when providing care.</p> <p>Review of the clinical record for Resident #7 revealed the facility readmitted the resident on 09/25/15 with diagnoses of Malignant Poorly Differentiated Neuroendocrine Tumors, Secondary Malignant Neoplasm of Brain, Hemiplegia Affecting Unspecified Side, Polyosteoarthritis, Abnormal Posture, Muscle Weakness, Apraxia, and Mental Disorder Not Otherwise Specified (NOS).</p> <p>Review of Resident #7's Admission Minimum Data Set (MDS) assessment, completed on 10/01/15, revealed the facility assessed the resident as requiring extensive two (2) person assist for bed mobility, transfers, dressing, and bathing. The facility did not conduct a Brief Interview for Mental Status (BIMS) exam at the time of the assessment due to the resident rarely or never understood, and the facility determined the resident was not interviewable.</p> <p>Observation, on 12/15/15 at 3:10 PM, revealed CNA #1 obtained the resident's weight. Resident #7 was dressed in a shirt and briefs with no pants on at the time the CNA obtained the weight. The CNA used a weight lift in the resident's room to obtain the resident's weight. The CNA did not</p>	F 164	<p>3. Re-Education on providing privacy during personal care by closing resident room door and the privacy curtain including provision of privacy when weighing a resident was conducted on or before 2/12/16 by Licensed Nurse and or Nurse Practice Educator for the Licensed Nurses and Certified Nursing Assistants. A post-test was administered at the time of the re-education with a passing score of 95% graded by the Director of Nurses or Nurse Practice Educator to validate understanding of the information presented. Staff not available at the time of the re-education will receive re-education with post-test by the Nurse Practice Educator upon return to work and including new hires during orientation.</p>	2/13/16

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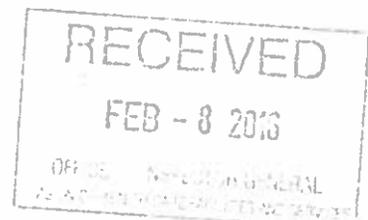
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F 164	<p>Continued From page 4 shut the resident's door or privacy curtain and Resident #7 pulled a blanket from the bed to cover his/her lap.</p> <p>Interview with Resident #7's Power of Attorney (POA), on 12/16/15 at 8:15 AM, revealed the POA was upset the staff left the door open while taking the resident's weight because the resident was not wearing pants and this was an invasion of the resident's privacy.</p> <p>Interview with CNA #1, on 12/16/15 at 10:25 AM, revealed the CNA did not close the door when she took Resident #7's weight. The CNA stated she did not think anybody could see the resident from the hallway due to the shape of the room and did not think about closing the privacy curtain or door while using the lift scale.</p> <p>Interview with Registered Nurse (RN) #1, on 12/16/15 at 5:25 PM, revealed when Resident #7 pulled the blanket over his/her legs during care was a non-verbal indication the resident was bothered by the lack of privacy afforded by CNA #1. RN #1 stated she was unaware and concerned the CNA left the door open to the resident's room while taking the resident's weight.</p> <p>Interview with the Nursing Facility 2 Unit (NF2 Unit) Manager, on 12/17/15 at 9:45 AM, revealed the CNA leaving the door open while taking the resident's weight was a violation of the resident's privacy. The CNA should have closed the resident's door prior to taking the resident's weight. She stated she conducted walking rounds throughout the day to make observations and to ensure staff provided privacy when providing care. She stated she had not observed CNA #1 providing care without privacy, but that</p>	F 164	<p>Visual observation with rounding audit to include observation of provision of privacy during care to include closing the resident room door and privacy curtain across all 3 shifts by the Unit Managers and or the Director of Nursing daily times two weeks including weekends, then three times a week times two weeks, then weekly times 8 weeks then every other week times 8 weeks then monthly times 1 month with corrective action /re-education upon discovery.</p> <p>4. The Director of Nursing and or the Nurse Practice Educator will submit a summary of the visual observation audits to include</p>	2/13/16
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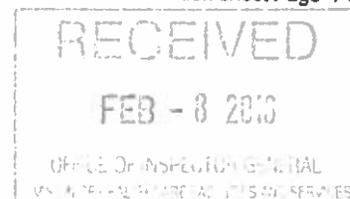
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F 164	Continued From page 5 she was concerned as staff recently conducted in-services pertaining to privacy in care.  Interview with the Director of Nursing (DON), on 11/17/15 at 11:23 AM, revealed the CNA should have ensured the privacy of Resident #7 by fully dressing the resident, pulling the privacy curtain, and closing the door prior to obtaining the resident's weight. By not ensuring the resident's privacy, the CNA violated the resident's right to privacy.  Interview with the Administrator, on 12/17/15 at 1:12 PM, revealed he was concerned staff did not provide privacy during care. The Administrator stated staff recently received education about providing privacy during care and were showing improvement in this area; however, he stated staff had room for improvement.	F 164	Privacy and confidentially to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director monthly for 6 months for any additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.		
F 167 SS=D	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 167	F167  1. Survey results and a posting of availability was place in the entrance way of the Homestead unit by the Administrator on December 30, 2015.	2/13/16	



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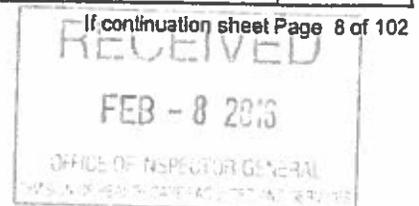
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F 167	Continued From page 6 determined the facility failed to post one (1) of one (1) notice to inform residents and visitors the survey results were available for examination.  The findings include:  Interview with the Administrator, on 12/17/15 at 1:45 PM, revealed there was no policy for the posting of survey results.  Observation of the front entrance to the facility, on 12/17/15 at 2:50 PM, revealed there was no sign posted to inform residents and visitors the survey results were available for examination.  Interview with the Receptionist, on 12/17/15 at 2:50 PM, revealed there had been no sign posted to inform residents and visitors of the survey results since she had been working at the facility for the last three (3) years.  Interview with the Administrator, on 12/17/15 at 1:45 PM, revealed he was not aware there was a requirement that a sign was to be posted to alert residents and visitors of the survey results.	F 167	2. All residents of the facility have the potential to be affected. The Administrator conducted rounds of the facility on December 30, 2015 to ensure that the sign was posted to inform residents and visitors the survey results were available for examination. No concerns were identified  3. Re-education will be completed with the Administrator and the Assistant Administrator regarding need to ensure the facility will make the results available for examination, post in a place readily accessible to residents, including a notice of availability by the Regional Vice President of Operation on or before February 12, 2016. A post-test will be completed at this time to validate understanding of the information presented.  Audits of the posting of the notice of availability will be conducted monthly for 6 months by the Administrator and or Assistant Administrator to determine signage is posted of the availability of the results. Areas of concern will be corrected upon discovery.	2/3/16	
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY  §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.  §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the	F 174			



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F 174	Continued From page 7 rights or health and safety of other residents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide reasonable access to a telephone where calls could be made without being overheard for one (1) of four (4) units. The telephone service for most of the Nursing Facility 1 Unit (NF1 Unit) was out for over five (5) days and residents had to make telephone calls at the Nurses' Station without privacy.  The findings include:  Review of the facility's Telephone Policy, revised 04/01/03, revealed telephones would be available at all times for residents to make and receive private telephone calls. Telephones would be in an area that offered privacy and accommodated the hearing impaired.  Observation of Resident #21, on 12/18/15 at 4:03 PM, revealed the resident was laying in bed watching television. A telephone was observed on the resident's night stand.  Interview with the resident, on 12/16/15 at 4:05 PM, revealed the telephone service had been out for about five (5) days. The resident stated the telephone was very important to him/her because it was their only method of communication with their daughter that lived out of state. The resident stated he/she talked with that daughter daily and it was very important to the resident because the daughter had multiple health problems and the resident worried about her. The resident stated another daughter had reported the telephone	F 174	4. The Administrator and or the Assistant Administrator will submit a summary of the audits to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director monthly for 6 months for any additional follow up and/or in-servicing needs until issue is resolved and ongoing thereafter.  F174  1. Phone service on NF1 to include resident #21's room was repaired on December 18, 2015 by corporate Information Technology Services. Resident #21 has not experienced any negative outcome.	2/13/16	



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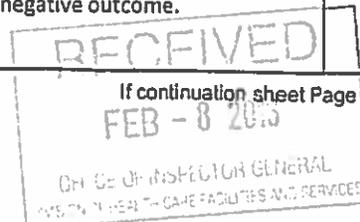
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F 174	<p>Continued From page 8</p> <p>outage several times and had been told the telephone company was working on the problem.</p> <p>Another interview with Resident #21, on 12/17/15 at 9:20 AM, revealed he/she still did not have any phone service. He/She stated the Administrator at first suggested the resident get out of bed and go to the Nurse's Station to make and receive phone calls, however, the resident stated it hurt so bad to get out of bed that was not an option. The resident stated the Administrator offered his personal cell phone, but the resident had a vision deficit and could not see the small numbers. The resident stated he/she really wished the telephone was fixed because he/she missed talking with his/her daughter daily.</p> <p>Observation of the NF1 Unit, on 12/16/15 at 4:25 PM, revealed telephones on the wall of the front, back and middle halls. However, the telephones had been placed above five (5) feet off the floor and not accessible to anyone in a wheelchair.</p> <p>Interview with the Administrator, on 12/17/15 at 8:40 AM, revealed he was informed on Sunday, December 13, 2015, the telephone lines on NF1 Unit was not working. The telephone at the Nurses' Station was working because it was on a different line. He stated a request (ticket) was put in to the Corporate ITT Department on Monday morning, 12/14/15. However, the Administrator revealed there had been no response. He stated Resident #21's daughter had called and complained about the phone outage. He stated he had offered his personal cell phone, but the resident declined. He stated residents could use the telephone at the Nurses' Station. He stated the facility did not have any portable telephones to give to the residents. The Administrator stated</p>	F 174	<p>2. All residents of the facility have the potential to be affected. The Maintenance Supervisor conducted rounds of all other units checking resident phone service to determine other areas of concerns on December 21, 2015. No other areas of concerns were identified.</p> <p>3. The Maintenance Director was re-educated regarding the resident's right to have reasonable access to the use of a telephone where calls can be made without being overheard by the Administrator on January 27, 2016. A Post-test was given at the time of the re-education to validate understanding of the information presented.</p> <p>The Administrator purchased a hand held phone device to enable residents of the facility to have reasonable access to the use of telephone where calls could be made without being overheard on January 24, 2016. The Maintenance Director and or Assistant Maintenance Director will conduct preventative maintenance rounds weekly times 4 weeks then every 2 weeks times 8 weeks then monthly times 3 months to</p>	2/13/16	

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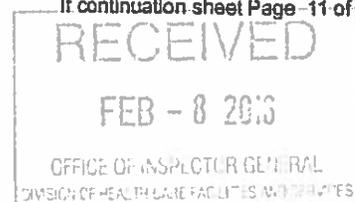
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/30/2015
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	
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F 174	Continued From page 9 the telephones on the wall could be used, but stated those telephones were usually used by staff.  Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, revealed he had placed a request to the Corporate ITT Department on 12/14/15 for repair. He stated the internal telephone lines from the residents' rooms on NF1 middle and North halls were not working and had no dial tone. The residents were unable to make or receive telephone calls and the residents could not call the Nurses' Station. He stated he put in an urgent request on 12/16/15 and a technician came to the facility on 12/17/15, determined the problem, and came back on 12/18/15 to repair the telephones.	F 174	Include phone service in resident rooms to determine service is in working order with corrective action/re-education upon discovery.  4. The Maintenance Director and or the Assistant Maintenance Director will submit a summary of the audits monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or in-servicing needs until the issue is resolved and ongoing thereafter.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to accommodate the needs of one (1) of thirty-seven (37) sampled residents. (Resident #7). The facility failed to honor the residents preference of showers instead of a bed baths.	F 246	F 246  1. The shower bed was repaired on December 17, 2015 by Maintenance Director. Resident #7 was given a shower upon repair of the shower bed by LPN on December 17, 2015. Resident #7 did not experience any negative outcome.	2/13/16



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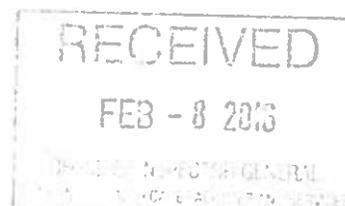
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F 246	<p>Continued From page 10</p> <p>The shower bed was broken and the resident had to receive bed baths against their preference.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Accommodation of Needs, dated 09/01/15, revealed the facility would make an effort to individualize the patient's physical environment to assist the resident in maintaining dignity and well-being to the extent possible in accordance with the patient's needs and preferences.</p> <p>Review of the clinical record for Resident #7 revealed the facility readmitted the resident on 09/25/15 with diagnoses of Malignant Poorly Differentiated Neuroendocrine Tumors, Secondary Malignant Neoplasm of Brain, Hemiplegia Affecting Unspecified Side, Polyosteoarthritis, Abnormal Posture, Muscle Weakness, Apraxia, and Mental Disorder Not Otherwise Specified (NOS).</p> <p>Review of Resident #7's Admission Minimum Data Set (MDS) assessment, completed on 10/01/15, revealed the facility assessed the resident as requiring extensive two (2) person assist for bed mobility, transfers, dressing, and bathing. The facility did not conduct a Brief Interview for Mental Status (BIMS) exam at the time of the assessment due to the resident rarely or never understood and the facility determined the resident was not interviewable.</p> <p>Interview with Resident #7's Power of Attorney (POA), on 12/16/15 at 8:15 AM, revealed the resident preferred to get a shower and not a bed bath. The POA stated the resident did not get a shower over the weekend because the shower</p>	F 246	<p>2. All residents of the facility have the potential to be affected. Bathing preferences were reviewed and updated by a Registered Nurse on January 4, 2016 to determine residents were receiving baths as they preferred. Areas of concern were corrected upon discovery. Currently, the facility does not have any other shower bed. Additional shower bed ordered.</p> <p>Licensed Nurses and CNAs will be re-educated on the resident's right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered including need to honor bathing preferences and the process of completing a work order for broken equipment by the Licensed Nurse and or Nurse Practice Educator on or before 2/12/16. A post-test will be given at the time of re-education to validate understanding of the information presented. Staff not available during this timeframe including new staff during orientation will be provided education and posttest by the Director of Nurses or Nurse Practice</p>	2/13/16	



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F 246	<p>Continued From page 11</p> <p>bed was broken. The POA stated he told the aides that the resident required a shower because the resident had fragile skin and because he/she had enjoyed showers. The POA stated a nurse did call him later that weekend and explained the shower bed was broken.</p> <p>Review of the Shower Log, for December 2015, revealed Resident #7 received a bed bath on 12/12/15 and on 12/16/15.</p> <p>Review of the Maintenance Log, for December 2015, revealed no entries pertaining to a broken shower bed.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 12/16/15 at 10:25 AM, revealed staff gave Resident #7 bed baths this week because the shower bed was broken. She stated she was unsure how long the shower bed had been broken, but that staff had given bed baths only in the last week per the shower log. CNA #3 stated she told the nurse about the broken equipment and assumed the nurse would communicate the issue to maintenance. CNA #3 stated she did not know of another way to communicate maintenance needs other than to tell the nurse of a maintenance issue.</p> <p>Interview with Registered Nurse (RN) #1, on 12/16/15 at 5:25 PM, revealed she had known about the broken shower bed and did not communicate it to the maintenance department. RN #1 stated she heard other staff discussing the shower bed being broken and a CNA told her that it was broken. RN #1 stated she did not report the broken equipment to maintenance or write it in the maintenance log because she believed, based on the conversation she overheard, staff</p>	F 246	<p>Educator to validate understanding upon return to work.</p> <p>3. The Director of Nursing and or Unit Managers will audit shower documentation to ensure bathing is provided according to resident preference daily x 2 weeks including weekends, then three times a week x 2 weeks, then every other week x 8 weeks then monthly time 3 month with corrective action/reeducation upon discovery.</p> <p>The Maintenance Director and of Assistant Maintenance Director will conduct preventive maintenance audits weekly times 4 weeks then every other week x 8 weeks then monthly time 3 month to determine equipment is in working order. Areas of concern will be corrected upon discovery.</p> <p>4. The Maintenance Director and or Assistant Maintenance Director will submit a summary of the audit findings for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator,</p>	2/13/16	



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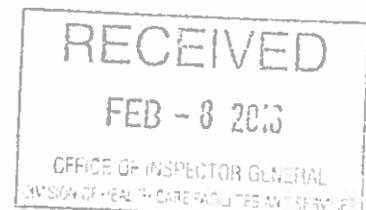
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F 246	<p>Continued From page 12</p> <p>had already reported the shower bed to maintenance. She did not follow up with the maintenance department. She stated she should have followed up, but did not because she assumed someone had already reported the issue to maintenance.</p> <p>Interview with Nursing Facility 2 Unit (NF2 Unit) Manager, on 12/17/15 at 9:45 AM, revealed the Unit Manager had no prior knowledge of the shower bed being broken. NF2 Unit Manager reviewed the Maintenance Log and stated no staff had reported the broken shower bed in the Maintenance Log or to her. The Unit Manager stated this was a concern because the resident did not get the shower he/she needed and had to settle for a bed bath instead. By not reporting the broken equipment so that the facility could fix it, the facility was not accommodating the needs of Resident #7.</p> <p>Interview with the Maintenance Director, on 12/17/15 at 10:10 AM, revealed the facility had one (1) shower bed for totally dependent residents to take showers. The Maintenance Director stated he first became aware of the broken equipment on 12/16/15 about 5:45 PM when nursing staff called to report the broken equipment. He stated staff did not write down the maintenance issue in either of the maintenance logs in the facility. The Maintenance Director stated staff could have reported maintenance issues by calling, emailing, or writing them in the maintenance log. Staff did not follow the process for reporting a maintenance concern.</p> <p>Interview with the Director of Nursing (DON), on 12/17/15 at 11:23 AM, revealed the nursing staff did not follow the process for reporting broken</p>	F 246	<p>Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p>	2/13/16

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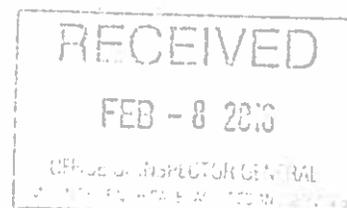
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F 246	Continued From page 13 equipment, which resulted in Resident #7 not getting desired showers. The DON further stated the facility had only one (1) shower bed. She stated it was necessary for the equipment to function and staff should have informed management of the issue immediately. Nursing, either CNAs or Nurses, should have notified maintenance of the broken shower bed by calling the maintenance department. The DON stated she was unsure if the facility had provided education or in-services to the nursing staff on how to report maintenance issues.  Interview with the Administrator, on 12/17/15 at 1:12 PM, revealed he became aware of the damaged shower bed in morning meeting on Monday morning (12/14/15). He stated a nurse attending the meeting discussed it. The Administrator stated morning meeting was one of the ways the facility communicated maintenance concerns to the maintenance department. Staff may also notify maintenance of concerns via the maintenance log system. The Administrator stated any staff could have reported a maintenance concern. The Administrator further stated Monday morning was the first day of employment for the Maintenance Director and stated he, the Administrator, did not follow up with the Maintenance Director to ensure items discussed in Monday morning meeting were completed. He further stated the facility did not keep notes of the morning meetings from which the Maintenance Director may have learned of the issue.	F 246			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program	F 248	F 248  1. The Activities Director re-assess resident #7 to determine current need for 1 on 1 activities on December 18, 2015. The care plan was updated at the time of the re-assessment to reflect the resident's current needs. Resident #7 has not experienced any negative outcome.	2/13/16	



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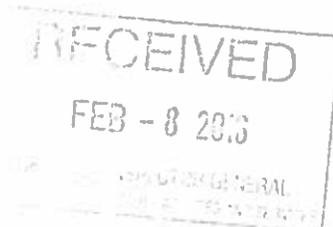
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F 248	<p>Continued From page 14</p> <p>of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure residents identified as needing one on one (1:1) activities were provided the activities for one (1) of thirty-seven (37) residents, Resident #7. Activity Assistant #1 and #2 did not provide one on one (1:1) activities for Resident #7 and were not aware the resident had been assessed for 1:1 activities.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident's Choice, dated 07/01/14, revealed the facility identified residents had the right to participate in activities of their choosing. The facility would provide opportunities for recreation and social involvement. The facility would invite residents to attend activities and would provide the opportunity for residents to participate in structured and individual activity programs. The facility would determine the preferences of individuals who were not interviewable through communication with the resident's family and caregivers. The facility would offer alternative activities to any residents who did not prefer to participate in structured programs.</p> <p>Review of Resident #7's clinical record revealed the facility re-admitted the resident on 09/25/15 with diagnoses of Malignant Poorly Differentiated</p>	F 248	<p>2. All residents of the facility have the potential to be affected. The Activities Director reviewed on December 18, 2015 all residents' activity assessments to determine if activities were being provided per interest and the physical, mental, and psychosocial well-being of each resident. Areas of concern were corrected upon discovery and the care plans were updated to reflect the current needs of the resident.</p> <p>3. The Activities Director conduct will re-educate regarding the need to ensure residents identified as needing one on one (1:1) activities were provided the activities as per resident plan of care with Activities Assistant #1 and #2 on or before February 12, 2016. A post- test was given at the time of the re-education with a passing score of 95% graded by the Activities Director to validate understanding.</p> <p>The Activities Director will complete visual observations audits of one on one activities 3</p>	2/13/16	



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F 248	<p>Continued From page 15</p> <p>Neuroendocrine Tumors, Secondary Malignant Neoplasm of Brain, Hemiplegia Affecting Unspecified Side, Polyosteoarthritis, Abnormal Posture, Muscle Weakness, Apraxia, and Mental Disorder Not Otherwise Specified (NOS).</p> <p>Review of Resident #7's Admission Minimum Data Set (MDS) activity assessment, completed on 10/01/15, revealed the facility assessed the resident's activity preferences to include magazines, listening to music, and group activities. The assessment also stated the resident found it important to listen to music, do his/her favorite activities, to do things with groups of people, and to participate in religion services or practices.</p> <p>Review of Resident #7's Comprehensive Care Plan revealed the facility developed an Activity Care Plan, on 11/11/15, with a goal of the resident demonstrating increased interest, increased motivation for involvement, and increased positive affect, with a target date of 01/01/16. The care plan also had a goal the resident would have increased social engagement as evidenced by participation in one to one (1:1) visits, small groups, and unstructured involvement with peers, family, friends, and staff. The interventions on the Activities Care Plan included staff would have established a relationship with the resident via one to one interventions, informal conversations and small groups and staff would provide frequent contact in order to develop rapport.</p> <p>Observations of Resident #7, on 12/15/15 at 11:15 AM, revealed 1:1 activities by facility staff did not occur as the resident was alone, in his/her room in a Geri Chair; at 12:15 PM the resident was alone, in his/her bed with eyes open; at 2:15</p>	F 248	<p>times a week including one weekend for 4 weeks then 2 times a week for 4 weeks, then weekly for 4 weeks then monthly for 3 months to ensure residents identified as needing one on one (1:1) activities are provided the activities with corrective action upon discovery.</p> <p>4. The Activities Director and or Activities Assistant will submit a summary of the audit findings monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p>	2/13/16	



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F 248	<p>Continued From page 16</p> <p>PM the resident was alone, in bed on his/her right side with his/her eyes closed. On 12/16/15 at 8:15 AM, the resident was in the Geri Chair and his/her Power of Attorney (POA) was visiting and no staff were present; at 11:00 AM, the resident was alone, in bed with his/her eyes open.</p> <p>Review of the Progress Notes between the dates of 09/28/15 and 11/14/15, revealed Activities did not make a Progress Note in the resident's clinical record.</p> <p>Interview with Resident #7's POA, on 12/16/15 at 8:15 AM, revealed staff had not discussed Resident #7's participation in 1:1 activities or small group activities with him. The POA had never seen the resident participating in any social activities in the facility. The POA further stated staff should be working with the resident more because he/she was not making progress.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 12/16/15 at 10:25 AM, revealed the facility did not provide activities for Resident #7. She stated Resident #7 did not participate in any group activities. The CNA stated the only social activities the resident received were when his/her POA visited.</p> <p>Interview with Nursing Facility 2 (NF2) Unit Manager, on 12/16/15 at 5:25 PM, revealed the Activities Department had not provided 1:1 activities to Resident #7. She stated the Activities Department was responsible for providing any scheduled 1:1 activities. She further stated she had not observed the resident in any small groups. She stated the only social activities the resident received was when his/her POA visited and the contact with CNAs and nurses.</p>	F 248	<p>INTENTIONALLY LEFT BLANK</p>	

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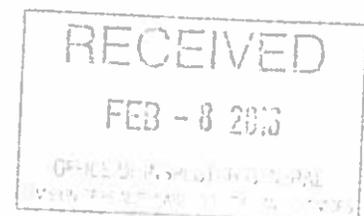
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F 248	<p>Continued From page 17</p> <p>Interviews with Activities Assistants' #1 and #2, on 12/17/15 at 9:10 AM, revealed the assistants completed the Activities Assessments for residents upon admission and quarterly. Activities Assistant #1 further stated after completing the Activities Assessment, the Activities Director placed the interventions on the Comprehensive Care Plan. However, the Activities Director had been on leave from the facility since 10/07/15. For residents who were dependent, Activities would provide a 1:1 activity program that included spending time with the resident in their room. The activities may include putting lotion on the resident's hands, singing to them, providing nail care, or another activity the resident may enjoy.</p> <p>Continued interview with Activities Assistant #2 revealed the Activities Department had not provided social activities for Resident #7, which placed the resident at risk of significant decline. She also stated she had not taken the resident to any small group activities, that the only thing she did was to hang the activities calendar in the resident's room and the only social activities the resident received was when his/her POA visited. Activities Assistant #2 further stated the activities plan should have been in addition to any social activities provided by the POA and the POA activities were not an adequate replacement for the activities program. Activities Assistant #2 stated without social activities the resident was at risk for depression and significant overall decline.</p> <p>Interview with the Administrator, on 12/17/15 at 1:12 PM, revealed he was providing oversight of the Activities Department while the Activities Director was on leave. The Activities staff should</p>	F 248	INTENTIONALLY LEFT BLANK	

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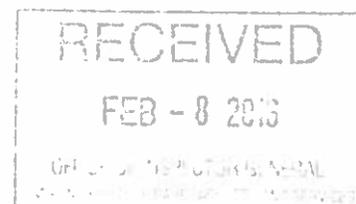
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F 248	Continued From page 18	F 248			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of housekeeping records, it was determined the facility failed to maintain a clean environment for three (3) of four (4) nursing units. Nursing units Nursing Facility 1 (NF1), Nursing Facility 2 (NF2), and the Transitional Care Unit (TCU) had multiple windows with a heavy build-up of dust and dirt. In addition, many of the windows had hand prints on them.  The findings include:  The facility did not provide a Housekeeping policy.  Review of the Healthcare Services Group Housekeeping Daily Routine, not dated, revealed from 10:15 AM-11:00 AM housekeepers were to complete deep cleaning of assigned rooms. In addition, from 11:00 AM to 12:00 PM housekeepers were to clean assigned resident rooms in accordance with the Daily Focus Calendar.  Review of the Healthcare Services Group Housekeeping Daily Focus Calendar, not dated,	F 253	1. NF1 and NF2 connecting hallway windows, NF1 Dining Room, rooms 101, 111, 129 TCU rooms 313, 327,408 NF2 rooms 205, 209 emergency exit door and NF2 common area door were clean on January 15, 2016 by Housekeeping.  2. All residents of the facility have the potential to be affected. The Housekeeping Supervisor conducted visual audit of the facility windows on January 16, 2016 to determine windows were clean. Areas of concern were corrected upon discovery.  3. The Housekeeping Supervisor implemented a cleaning schedule for the outside windows on December 31, 2015. The Housekeeping Supervisor conducted re-education regarding the need to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior with the housekeepers regarding the cleaning schedule on or before February 12, 2016. A post-test was given at the time of the re-education to validate understanding of the information presented.	2/13/16	



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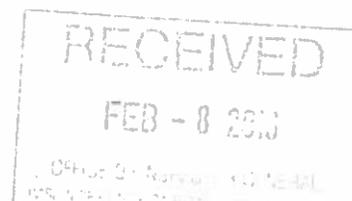
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F 253	<p>Continued From page 19</p> <p>revealed Windows, Blinds, and Window sills were cleaned every Sunday.</p> <p>Review of the Healthcare Services Group Deep Clean Check off List, not dated, revealed housekeepers were to clean window sills and the inside of the windows as part of daily deep cleaning tasks.</p> <p>Observation of the Hallway between NF1 and NF2 Units, on 12/16/15 at 3:55 PM, revealed the outside of the windows had a white film and were soiled with dirt.</p> <p>Observation of the NF1 Unit Dining Room, on 12/16/15 at 4:17 PM, revealed the inside of one window was splattered with a hard white substance.</p> <p>Observation of the Transitional Care Unit (TCU), on 12/17/15 at 9:35 AM, revealed Resident Rooms 313, 327, and 408 had a build-up of dirt on the outside of the windows. In addition, Resident Room 408 was streaked with dried bird feces.</p> <p>Observation of the NF2 Unit, on 12/17/15 at 9:46 AM, revealed Resident Rooms 205 and 209 had a white film on the windows with dirt and dust build-up. In addition, the Emergency Exit door on the front hall had dirt built-up and large cobwebs on the outside of the windows. The door in the NF2 Unit common area leading to the Courtyard had a build-up of dirt on the outside of the windows and was covered with hand and finger prints on the inside and outside of the windows.</p> <p>Observation of the NF1 Unit, at 9:53 AM on 12/17/15, revealed Resident Rooms 101, 111,</p>	F 253	<p>The Housekeeping Supervisor, Administrator and or Assistant Administrator will conduct visual audits of the facility windows weekly for 4 weeks, bi weekly for 2 months and monthly for 3 months to ensure interior and exterior windows and doors are clean with corrective action upon discovery.</p> <p>4. The Housekeeping Supervisor, Administrator and or Assistant Administer will submit a summary of the audit findings monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p>	2/13/16



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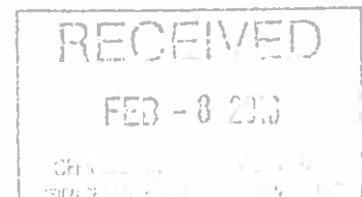
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F 253	<p>Continued From page 20 and 129 had a buildup of dust and dirt on the outside of the windows.</p> <p>Interview with Unsampled Resident N, on 12/17/15 at 4:40 PM, whom the facility assessed with a Brief Interview for Mental Status (BIMS) score of fifteen (15) on 11/27/15, and determined the resident was interviewable, revealed windows were dirty and difficult to see out of.</p> <p>Interview with the Housekeeping Supervisor, on 12/16/15 at 3:45 PM, revealed Housekeeping staff were contracted through Healthcare Services Group to provide services to the facility. The Housekeeping Director stated the inside of the windows were cleaned daily; however, he did not know of a cleaning schedule for the outside of the windows and did not know the last time they were cleaned. The Housekeeping Supervisor stated he was aware of the dirty windows throughout the building and this concern was discussed approximately one month ago when the District Manager for Healthcare Services and the Regional Maintenance Director were in the building. The Housekeeping Supervisor stated since then nothing had been done to follow up on the dirty windows concern and he had not scheduled a cleaning for the outside windows.</p> <p>Interview with the Administrator, on 12/17/15 at 11:22 AM, revealed the outside windows should be cleaned twice a year per the facility contract with Healthcare Services Group. In addition, the Administrator stated it was the responsibility of the Housekeeping Supervisor to monitor the cleanliness of the windows and set up appointments for window cleaning when needed. The Administrator stated the windows were dirty and in need of cleaning. In addition, he stated a</p>	F 253	INTENTIONALLY LEFT BLANK	



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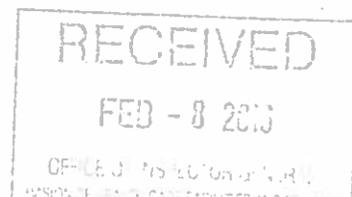
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F 253  F 274 SS=D	<p>Continued From page 21 few months ago the Resident Counsel did have a concern with the cleanliness of the windows; however, he did not remember what, if any, action was taken to correct the dirty windows. The Administrator did not provide any evidence of any action taken to clean the dirty windows.</p> <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, and review of the Resident Assessment Instrument (RAI) Manual it was determined the facility failed to conduct a significant change in status for one of thirty-seven (37) sampled residents. Resident #18 sustained a hip fracture with a major decline in two or more areas of mobility that did not resolve itself without further interventions. The facility failed to identify the significant change and did not conduct the assessment.</p>	F 253  F 274	<p>F 274</p> <ol style="list-style-type: none"> <li>1. A Significant Change Assessment/Correction was completed for resident #18 on December 17, 2015 by MDS Nurse. Resident # 18 has not experienced any negative outcomes. The care plan was updated to reflect resident's current status at the time of the correction.</li> <li>2. All residents of the facility have the potential to be affected. The Clinical Reimbursement Manager and or the MDS Nurse completed a review of the residents readmitted to the facility since September 30, 2015 on January 27, 2016 to ensure that a Significant Change in Status Assessment is completed when a residents meets the significant change guidelines for either improvement or decline. Areas of concerns were corrected upon discovery.</li> <li>3. The Regional Clinical Reimbursement Specialist conducted re-education regarding a facility must conduct a comprehensive assessment of a resident</li> </ol>	2/13/16



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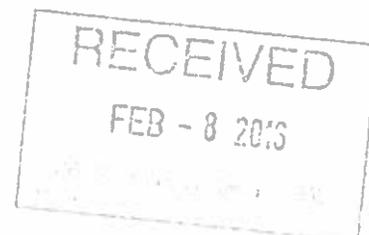
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F 274	<p>Continued From page 22</p> <p>The findings include:</p> <p>The facility did not provide a specific policy for Significant Change Assessments.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 12/17/15 at 3:12 PM, revealed she used the Resident Assessment Instrument (RAI) Manual for reference.</p> <p>Interview with the Corporate Manager of Clinical Operations, on 12/17/15 at 1:07 PM, revealed the facility used the RAI process.</p> <p>Review of the RAI Manual 3.0, dated October 2014, Chapter 2, page 2-20, revealed a Significant Change in Status Assessment (SCSA) is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either improvement or decline. A significant change is a decline or improvement that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; is not self-limiting; impacts more than one area of the resident's health status; and, requires interdisciplinary review and/or revision of the care plan.</p> <p>Review of the clinical record for Resident #18 revealed the the facility re-admitted the resident on 10/16/15 with a status post Hip Fracture that required surgical intervention. Other diagnoses included Dementia, Osteoporosis, Abnormal Gait, and Depression.</p> <p>Review of the Quarterly MDS Assessment, dated 10/05/15, previous to surgery, revealed the</p>	F 274	<p>within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition with the MDS Nurses on January 14, 2016. Re-education included the definition of significant change. A post-test was given at the time of the re-education to validate understanding of the information presented.</p> <p>The CRC and or MDS Nurse will audit 10 resident clinical records including residents readmitted to the facility for significant change weekly for 4 weeks, bi-weekly for 8 weeks and monthly for 3 months to ensure that a Significant Change in Status Assessment is completed when resident meets the significant change guidelines for either improvement or decline. Areas of concern will be corrected upon discovery.</p>	2/13/16



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F 274	<p>Continued From page 23</p> <p>resident was independent with Activities of Daily Living (ADLs) prior to the hip fracture. Review of the most current Quarterly MDS Assessment, dated 10/22/15 revealed the facility assessed the resident as dependent with Activities of Daily Living (ADL) and required extensive to total assist from staff with bed mobility, transfers, ambulation, locomotion, eating, dressing, toilet use, personal hygiene, and bathing. These declines were noted after the hip fracture and surgery.</p> <p>Review of the comprehensive care plan related to the hip fracture, dated 10/22/15, revealed revision of the care plan was required as a result of the hip fracture that impacted the resident's ability to function independently. Physical and Occupational therapy were required to improve the resident's mobility status.</p> <p>Interview with the MDS Coordinator, on 12/17/15 at 3:12 PM, revealed the staff followed the RAI Manual to determine if a significant change in status assessment was required. She stated two or more areas of decline or improvement would be required. She stated the facility's computer software should have red flagged the changes. She stated the interdisciplinary team would discuss the changes to determine if it was a true change or temporary. She stated the staff could override the computer software and stated a Significant Change in Status Assessment should have been conducted because the decline was not self-limiting. She could not say why the assessment was not conducted, because she had not conducted the assessment.</p> <p>Interview with the Case Manager for MDS, on 12/17/15 at 3:59 PM, revealed she had called the person who had conducted the Quarterly</p>	F 274	<p>4. The CRC and or MDS nurse will submit a summary of the audit findings monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p>	2/13/16



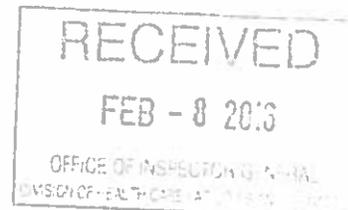
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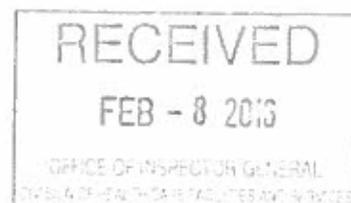
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F 274	Continued From page 24 Assessment instead of the Significant Change in Status Assessment. She stated she thought the resident's declines were self-limiting related to an acute condition (hip fracture) and once the resident received therapy would return to baseline. She stated a Significant Change in Status Assessment should have been conducted according to the RAI Manual.	F 274		
F 281 SS-D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to follow professional standards of practice to ensure medications were signed by the nurse after administering medications for two (2) of fourteen (14) unsampled residents, (Unsampled Residents J and K). Licensed Practical Nurse (LPN) #1 signed the medication administration record as giving the medications prior to administering the medications to Unsampled Residents J and K.  The findings include:  Review of the facility's policy, regarding General Dose Preparation and Medication Administration, dated 12/17/15, revised 03/01/11, revealed after medication administration, staff was to document the necessary medication administration information when medications were given.	F 281	F 281  1. LPN #1 received re-education by the Director of Nursing on December 17, 2015 medication administration including not signing the medication as given before administering the medications. Resident J and K received their medication as ordered on December 17, 2015 as validated by the surveyor observation and have not experienced any negative outcome.  2. All residents of the facility have the potential to be affected. Visual observations were conducted by the Unit Managers on December 17, 2015 to determine services were being provided to meet professional standards of quality to include the medications administration record signed after administration of medications. Areas of concern were corrected upon discovery.	2/13/16



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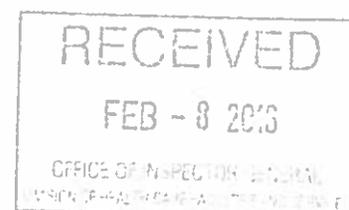
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F 281	<p>Continued From page 25</p> <p>Review of the Lippincott Nursing Center eNews, dated 05/27/11, revealed the five (5) rights of medication administration had three (3) added to the list. In addition to the Right Patient, Right Medication, Right Dose, Right Route, and Right Time, the Right Documentation, Right Reason and Right Response were added. Under the Right Documentation it stated to document AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary.</p> <p>Observation, on 12/16/15 at 8:15 AM, of the medication pass on the 100 Hall revealed Licensed Practical Nurse (LPN) #1 signed that the medications were given prior to administration to Unsamped Resident J. Next LPN #1 proceeded to provide medications to Unsamped Resident K and she signed for the medications before administering them to the resident.</p> <p>Interview, on 12/16/16 at 9:07 AM, with LPN #1 revealed she understood a resident's right to refuse a medication. LPN #1 stated she had to sign for the medications regardless if a resident took them or refused them. She questioned what difference did it make if she signed for the medications now or after she gave them and then stated if a resident did not take the medication, she would circle the medication.</p> <p>Interview with Director of Nursing (DON), on 12/16/15 at 4:06 PM, revealed she expected nurses to know medication rights. She stated the nurses would knock on the door, explain the medications to a resident, administer medications as directed and then a nurse would sign for the medications after they had been administered.</p>	F 281	<p>3. The Nurse Practice Educator and or a Pharmacy Representative conducted re-education for Licensed Nurses covering Medication administration including not signing the medication as given before administering the medication on January 15, 2016. A medication administration competency was completed after the re-education to determine understanding of the information presented. Staff not available during this timeframe including new nurses during orientation will be provided reeducation including medication administration competency by the Director of Nurses or Nurse Practice Educator upon return to work.</p> <p>Visual observation of medication pass audits will be conducted over all 3 shifts by the Director of Nursing and or Unit Managers to determine the care provided meets professional standards of quality to include the Medication Administration Record is not signed until after the medication is administered 2 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 4 months with corrective action upon discovery.</p>	2/13/16



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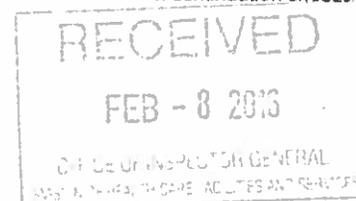
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F 282 F 282 SS=J	Continued From page 26 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure staff implemented the care plan interventions for three (3) of thirty-seven (37) sampled residents. Residents #7, #9 and #29.  The facility assessed Resident #29 to have elopement tendencies due to the resident's history. The facility developed a care plan with a goal that the resident would not leave the building without an escort. A Wander Guard device was applied to alert staff when the resident attempted to leave the building. On 12/16/15 at approximately 5:35 AM, Resident #29 eloped from the building without staff knowledge. The resident was found in the middle of a busy road with two (2) cars from opposite directions flashing their lights to avoid hitting the resident. Upon return to the facility, the resident's Wander Guard device activated the exit door's alarm. The resident was assessed and found with no injuries. The facility's investigation determined the alarming exit doors were functioning properly; however, facility staff had failed to respond to the alarm according to facility policy. The staff failed to search the area around the alarming door	F 282 F 282	4. The Director of Nursing and or the Unit Managers will submit a summary of the audit findings monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or in-servicing needs until the issues is resolved and ongoing thereafter.  F282  1. On 12/16/15 a Licensed Nurse completed an evaluation of the resident to include vital signs taken that were all within usual range for Resident #29. Resident was noted by the LPN to be able to move all extremities without difficulty and without complaints of pain or discomfort. No new skin issues were identified. Resident was placed on 1 on 1	2/13/16	



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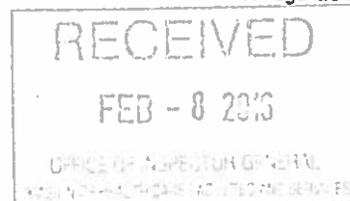
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F 282	<p>Continued From page 27 (including looking outside) and failed to ensure all residents were present. (Refer to F323)</p> <p>In addition, the facility failed to provide assistance with bathing for Resident #9, who required assistance of one by staff for bathing needs. The Activities Department failed to provided assessed one on one (1:1) activities for Resident #7 as care planned.</p> <p>The facility's failure to follow the plan of care for residents placed those residents in a situation that has caused or is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/18/15 and determined to exist on 12/16/15. The facility was notified of the Immediate Jeopardy on 12/18/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 12/23/15 which alleged removal of the Immediate Jeopardy on 12/22/15. The State Survey Agency verified Immediate Jeopardy was removed on 12/22/15 as alleged, prior to exit on 12/30/15. The Scope and Severity was lowered to a "D" while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, revision date of 01/02/14, revealed the resident care plan would include measurable objectives to meet patient needs and goals as identified by the assessment process. The purpose of care plans was to provide necessary care and services to attain or maintain the resident's highest practicable physical, mental,</p>	F 282	<p>observation, elopement assessment and care plan was updated to reflect current status. The Physician and Responsible Party were notified. The resident was transferred to Regis Woods Alzheimer's nursing unit on 12/16/15. On 12/16/15 the Physician completed a full assessment and determined that Resident # 29 did not sustain any negative outcome.</p> <p>Resident #9 received a shower on December 15, 2015 upon discovery. Resident #9 has not experience any negative outcome. The care plan was reviewed and updated to reflect assistance needed with bathing by Unit Manager on December 17, 2015.</p> <p>The Activities Director re-assess resident #7 to determine current need for 1 on 1 activities on December 18, 2015. The care plan was updated at the time of the re-assessment to reflect the resident's current needs. Resident #7 has not experienced any negative outcome.</p>	2/13/16	



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F 282	<p>Continued From page 28 and psychosocial well-being.</p> <p>Interview with the Corporate Manager of Clinical Operations, on 12/17/15 at 1:07 PM, revealed the facility used the Point Click (computer software program) library to develop the resident's care plan. Outside of that, the facility used the Resident Assessment Instrument (RAI) process.</p> <p>Review of the facility's policy regarding Elopement of residents, revision date of 05/15/14, revealed all residents would be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing assessment process. Those determined to be at risk for elopement would receive appropriate interventions to reduce risk and minimize injury. For those residents identified at risk, an interdisciplinary elopement prevention care plan would be developed with individual risk factors and patterns identified and addressed within the care plan.</p> <p>1- Review of the clinical record for Resident #29 revealed the resident had resided at the facility since 07/17/13. Review of the most current diagnoses included: Dementia, Muscle Weakness, Abnormal Posture, Hypothyroidism, Depression, and Anxiety Disorder.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/02/15 and the Quarterly MDS Assessment, dated 10/20/15, revealed the facility assessed the resident to have a severe cognition loss with a Brief Interview for Mental Status (BIMS) score of three (3) out of possible fifteen (15). The facility assessed the resident to require minimum assistance from staff with ambulation (with a walker) in the room and</p>	F 282	<p>2. All residents of the facility have the potential to be affected. A visual observation was conducted by Activities Director, Unit Managers, and Director of Nursing on or before February 12, 2016 to determine residents are receiving activities as per assessment including 1 on 1 activities, baths/showers were completed a minimum of two per week and/or per resident choice and supervision needs were in place to prevent elopement as care planned with corrective action upon discovery.</p> <p>3. The Director of Nursing, Nurse Practice Educator or Administrator beginning on 12/16/15 with completion on 12/21/15. 205 employees in facility, which includes 5 agency Dietary staff and 16 agency Housekeeping/Laundry staff with received the education and training the same as facility staff. 171 employees completed the education.</p>	2/13/16	



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F 282	<p>Continued From page 29 outside in the corridor.</p> <p>Review of the comprehensive care plan, revised 12/17/15, revealed a care plan was developed on 05/14/15 for risk of elopement related to the resident's cognition loss and diagnosis of Dementia. The care plan stated the resident would wander and exit seek. The goal was for the resident not to leave the building without an escort. The interventions implemented on 05/14/15 included: encourage independence while in the building, but ensure supervision while outside, educate staff of elopement potential, triggers, and prevention measures, and if unable to redirect resident, stay with the resident and provide support and supervision. On 11/09/15, the care plan was revised to include a Wander Guard device with placement and function to be checked. An additional intervention was added on 11/09/15 that instructed staff to document any unsafe wandering and notify the physician and family.</p> <p>Review of a progress note, dated 12/16/15 at 7:16 AM, revealed the resident was found outside. Review of the facility's investigation revealed Resident #29 left the building through Entrance B doors without staff knowledge. The resident was found walking with a rolling walker in the middle of a busy road, between two (2) cars from opposite directions, flashing their head lights to avoid hitting the resident. The facility's investigation revealed facility staff failed to respond to the door alarm and search the surrounding area (including outside) according to facility policy. In addition, the investigation revealed someone had silenced the alarm, but nobody admitted to the act.</p>	F 282	<p>Re-education included:</p> <ul style="list-style-type: none"> <li>• Need to follow each resident's care plan and Kardex regarding potential for elopement with the interventions for resident safety.</li> <li>• Each employee completed a post-test to validate learning. This grading was completed by the Nurse Practice Educator, Director of Nursing, or Assistant Director of Nursing or administrator between 12/16/15 -- 12/21/15 with no employee working without a passing score.</li> </ul> <p>Active employees completed re-education and posttest to validate understanding between 12/16/15 -- 12/21/15. All employees scheduled to work on the dates of 12/16/15 through 12/21/15 received education prior to or during the shift.</p>	2/13/16
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F 282	<p>Continued From page 30</p> <p>Post survey interview with CNA #22, on 01/20/16 at 11:52 AM, revealed she knew the resident had behaviors of wandering and exit seeking and had a WanderGuard device. The resident was independent with dressing, transfers, and ambulation. She stated the resident walked with a walker and walked very fast. She would look in the ADL book at the nurses station that included care plans to find out what the resident's care needs were. The resident's supervision level was the same for any resident at that time, check on the resident every two hours. She stated she had access to the care plan through the ADL book and the nurses would update that book for the aides. If she did not know the resident's care plan interventions she would look in the ADL book. It was her first time caring for Resident #29. At the time of the elopement the CNA was in another resident's room getting them up for the day. The last time she saw Resident #29 was around 4:30 AM. The resident was in her room, dressed, and sitting in the recliner.</p> <p>Interview with Licensed Practical Nurse (LPN) #12, on 12/17/15 at 6:14 PM, revealed he worked Nursing Facility 2 (NF2) Unit and was responsible for Resident #29 the morning the resident eloped from the building. He stated the resident had been identified at risk for elopement and there had been talk regarding moving the resident to the secure unit prior to the elopement, but couldn't say when. He stated staff was familiar with the resident's wandering and was to provide supervision to prevent an elopement. He stated he saw the resident at 5:20 AM, and did not know when he/she had left the unit.</p> <p>Post survey interview with LPN #12, on 01/19/16 at 7:01 PM, revealed he did not know the</p>	F 282	<p>Employees not available during this time period and not scheduled through 12/21/15 were contacted via telephone by each employee's immediate supervisor to be made aware that reeducation with posttests will be required prior to the next scheduled shift. New employees will receive education including posttest during orientation including any new agency staff. Learning will be validated at the time of completion with a passing score of 95% by the Nurse Practice Educator, Director of Nursing, or Assistant director of Nursing or Administrator.</p> <p>The Director of Nursing Services or Nurse Practice Educator will reeducate licensed and certified nursing staff on or before 2/12/16 regarding the need to ensure residents received the necessary services to maintain good personal hygiene including preferred shower/bath schedule with a posttest to validate understanding with a passing score of 95% graded by the Director of Nurses or Nurse</p>	2/13/16	

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F 282	<p>Continued From page 31</p> <p>Interventions for Resident #29 in regards to supervision to prevent elopement, but he could look at the Kardex or the care plan on the electronic clinical record. As far as the implementation of the care plan he said he had just seen the resident five minutes before and she was just a regular supervision not a one to one (1:1). He stated the WanderGuard device was part of the supervision to alert staff when the resident was attempting to leave the building. He stated he had not checked Resident #29 or any residents who utilized a WanderGuard device when the door alarm activated nor had he checked anyone else. He would not normally check residents with the WanderGuard device when the door alarm activated. He stated he thought he had followed the care plan. He further stated he could not know the whereabouts of all residents unless they were on 1:1 supervision. Resident #29 was not on 1:1 supervision at the time of the elopement.</p> <p>2. Review of Resident #9's clinical record revealed the facility admitted the resident on 07/08/15, with diagnoses of Congestive Heart Failure, Gastric Cancer, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Hypertension, Gastroesophageal Reflux Disease, Obesity, Muscle Weakness, Chronic Pain, Depression, Insomnia, Anxiety, Neuropathy, and Osteoarthritis.</p> <p>Resident #9's Quarterly Minimum Data Set (MDS), dated 10/15/15, assessed the resident with a Brief Interview for Mental Status (BIMS) of a fifteen (15), meaning the resident was interviewable. In addition, the facility assessed Resident #9 as totally dependent on staff for bathing, and required a one person physical</p>	F 282	<p>Practice Educator. Staff not available during this timeframe including new hires with orientation will complete reeducation with a posttest by the Director of Nurses or Nurse Practice Educator to validate understanding upon return to work.</p> <p>The Activities Director will conduct re-education regarding the need to ensure residents identified as needing one on one (1:1) activities were provided the activities as per resident plan of care to Activities Assistant #1 and #2 on or before February 12, 2016. A post-test was given at the time of the re-education with a passing score of 95% graded by the Activities Director to validate understanding.</p> <p>As of 12/16/15 the Administrator, Assistant Administrator and/or Director of Nursing have assigned designated audits to the administration and management staff during morning meeting to ensure that the audits are completed. They will be reviewed in morning meeting and during Quality Improvement Committee (QIC) for completeness and corrective action upon discovery</p>	2/13/16

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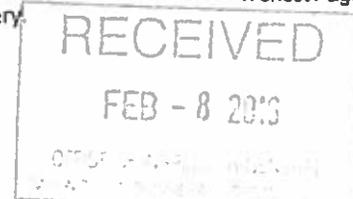
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F 282	<p>Continued From page 32 assistance with bathing.</p> <p>Review of Resident #9's Care Plan initiated on 07/10/15 revealed the focus was the resident was dependent for Activities of Daily Living (ADL) care in bathing due to chronic disease. The goal, initiated on 07/10/15 with a target date of 02/26/16, was for Resident's ADL care needs to be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being for the next ninety (90) days. The intervention, initiated on 07/10/15, was the resident required total to extensive assistance with bathing tasks.</p> <p>Review of NF1 Shower Schedule, revealed Resident #9 was to get a shower every Tuesday and Friday on the first shift.</p> <p>Review of the Weekly Bath and Skin Report for Resident #9, revealed on 12/02/15 the form did not identify what type of hygiene was provided, 12/08/15 a bed bath was provided, and on the 12/15/15 the resident refused three times. Resident #9 did not receive a shower/bath on 12/04/15 or 12/11/15, which was his/her designated shower days. In addition, review of Resident #9's ADL Record, dated 12/01/15 through 12/16/15, revealed from 12/04/15 to 12/11/15, he/she did not receive a bath/shower, or sponge bath; an eleven (11) day time span.</p> <p>Observation of Resident #9, at 12:45 PM on 12/15/15, revealed he/she was laying in bed on his/her back, dressed in a hospital gown. Resident #9's hair was greasy, and matted to his/her head.</p> <p>Interview with Resident #9, at 5:05 PM on</p>	F 282	<p>Care plan implementation for residents identified to be at risk for elopement upon admission, readmission and/or change in condition will be initiated upon identification of the risk for elopement as determined by the elopement risk evaluation by a licensed practical nurse or registered nurse. These care plans will be reviewed starting on 12/17/15 through the morning clinical meeting process daily Monday to Friday and on weekends by the charge nurse of the unit with corrective action upon discovery.</p> <p>Elopement risk care plans for 5 residents identified at risk for elopement will be audited starting on 12/17/15 by the DNS, ADNS, NPE, CRC, or Administrator for following the care plan implementation and accuracy daily across all shifts X 14 days including weekends, then 5 X per week X 14 days, then no less than 3 X per week for an additional 20 weeks. Additional audits will be determined by the monthly Quality Improvement Committee (QIC). Corrective action and/or re-education will be provided at point of discovery.</p>	07/13/16	

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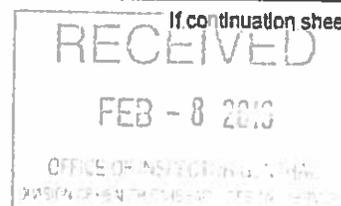
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F 282	<p>Continued From page 33</p> <p>12/15/15, revealed he/she was not getting showers or bed baths consistently and on average he/she was given a shower or bed bath only once per week. Resident #9 stated it made him/her feel bad when she wasn't clean.</p> <p>Interview with CNA #4, on 12/16/15 at 8:07 AM, revealed Resident #9 was totally dependent on staff for bathing needs and showers were provided based on the shower schedule; however, the resident would refuse at times. Refusals must still be documented in the shower book, so staff would know a shower was attempted. He further stated they would attempt a second time and if the resident refused and they would notify the nurse or the Unit Manager. However, review of the weekly shower and skin report revealed there was no documentation for 12/04/15 or 12/11/15.</p> <p>Interview with CNA #7, on 12/15/15 at 8:05 AM and 12:17 PM, revealed the resident needed assistance with showers and bathing. However, she did not provide care to Resident #9 during the days of 12/04/15 through 12/11/15.</p> <p>Interview with the NF1 Unit Manager, on 12/17/15 at 1:25 PM, revealed care plans should be followed by all staff per facility policy. She stated she reviewed the shower sheets and used Sundays as a make up day for those residents who missed their shower. Review of the ADL record for December revealed the 6th was a make up opportunity; however, the record was documented with all eights meaning activity did not occur. In addition, the Unit Manager stated Resident #9 was dependent on staff for bathing/shower needs, and the facility was not meeting his/her needs. The NF1 Unit Manager</p>	F 282	<p>Visual observation audits will be conducted by the Director of Nursing, Unit Managers, Assistant Administrator, Activity Director and Or Licensed Nurse to determine the needs of the residents are met per the plan of care 3 times a week times 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks then monthly for 3 months. Identified concerns will be corrected immediately upon discovery.</p> <p>The Director of Nursing and or Unit Managers will audit shower documentation to ensure bathing is provided according to resident preference daily x 2 weeks including weekends, then three times a week x 2 weeks, then every other week x 8 weeks then monthly time 1 month with corrective action/reeducation upon discovery.</p> <p>The Activities Director will complete visual observations audits of one on one activities 3 times a week including one weekday for 4 weeks then 2 times a week for 4 weeks, then weekly for 4 weeks then monthly for 3 months to ensure residents identified as needing one on one (1:1) activities are provided the activities with corrective action upon discovery.</p>	2/13/16



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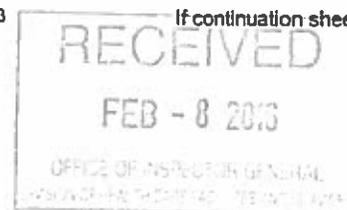
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F 282	<p>Continued From page 34</p> <p>stated staff was not providing care in accordance with Resident #9's ADL care plan.</p> <p>Interview with the Director of Nursing (DON), at 2:20 PM on 12/17/15, revealed care plans were developed based upon the specific needs assessment of each resident. In addition, the DON stated it was facility policy for resident care plans to be implemented, updated, and followed. The DON revealed, all activities of daily living (ADLs), including showers/baths, should be care planned and followed by all staff. The DON stated the documentation did not prove shower/bathing assistance was being provided consistently, nor was facility staff meeting Resident #9's ADL care needs identified in his/her care plan.</p> <p>3. Review of Resident #7's clinical record revealed the facility re-admitted the resident on 09/25/15 with diagnoses of Malignant Poorly Differentiated Neuroendocrine Tumors, Secondary Malignant Neoplasm of Brain, Hemiplegia Affecting Unspecified Side, Polyosteoarthritis, Abnormal Posture, Muscle Weakness, Apraxia, and Mental Disorder Not Otherwise Specified (NOS).</p> <p>Review of Resident #7's Admission Minimum Data Set (MDS) activity assessment, completed on 10/01/15, revealed the facility assessed the resident's activity preferences to include magazines, listening to music, and group activities. The assessment also stated the resident found it important to listen to music, do his/her favorite activities, to do things with groups of people, and to participate in religion services or practices.</p> <p>Review of Resident #7's Comprehensive Care</p>	F 282	<p>4. An adHoc Quality Improvement Committee meeting will be held more frequent when determined by Management and Administration to continue to ensure our plans are effective. The meeting will be with the Administrator, DNS, Admissions Director, Clinical Case Manager, Nurse Practice Educator, and Social Worker. The Medical Director will be notified when an adHoc OIC is conducted via telephone by the Administrator.</p> <p>Findings will be reviewed with the Quality Improvement Committee (QIC) by the Administrator monthly times 6 months or until the issue is resolved and ongoing thereafter. The QIC committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Admissions and Marketing Coordinator, Activities Director, Social Services Director, Clinical Reimbursement Manager, Maintenance Director, Nurse Practice Educator, Nutrition Services Director and Medical Director.</p>	2/13/16	



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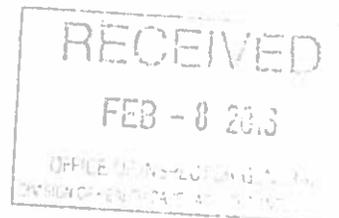
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F 282	<p>Continued From page 35</p> <p>Plan revealed the facility developed an Activity Care Plan, on 11/11/15, with a goal of the resident demonstrating increased interest, increased motivation for involvement, and increased positive affect, with a target date of 01/01/16. The care plan also had a goal the resident would have increased social engagement as evidenced by participation in one to one visits, small groups, and unstructured involvement with peers, family, friends, and staff. The interventions on the Activities Care Plan included staff would have established a relationship with the resident via one to one interventions, informal conversations and small groups and staff would provide frequent contact in order to develop rapport.</p> <p>Observations of Resident #7, on 12/15/15 at 11:15 AM, revealed one on one (1:1) activities by facility staff did not occur as the resident was alone, in his/her room in a Geri Chair; at 12:15 PM the resident was alone, in his/her bed with eyes open; at 2:15 PM the resident was alone, in bed on his/her right side with his/her eyes closed. On 12/16/15 at 8:15 AM, the resident was in the Geri Chair and his/her Power of Attorney (POA) was visiting and no staff were present; at 11:00 AM, the resident was alone, in bed with his/her eyes open.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 12/16/15 at 10:25 AM, revealed the facility did not provide activities for Resident #7 and the resident did not participate in any group activities. CNA #3 had never observed staff providing the resident with 1:1 activities per the resident's plan of care.</p> <p>Interview with NF2 Unit Manager, on 12/16/15 at 5:25 PM, revealed the Activities Department had</p>	F 282	<p>INTENTIONALLY LEFT BLANK</p>	2/13/16



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PRINTED: 01/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/30/2015
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	
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F 282	<p>Continued From page 36</p> <p>not provided 1:1 activities to Resident #7. However, the Activities Department was responsible for providing any scheduled 1:1 activities. She had not observed the resident in any small groups and the only social activities the resident received was when his/her POA visited and the contact with CNAs and nurses.</p> <p>Interviews with Activities Assistants' #1 and #2, on 12/17/15 at 9:10 AM, revealed the Activities Department had not been providing 1:1 activities for Resident #7 per the resident's assessment and care plan. The Activities Assistant #1 reviewed the care plan and stated she was unaware Resident #7 was placed on a 1:1 activity schedule and the resident had not been receiving the 1:1 activities.</p> <p>Continued interview with Activities Assistant #2 revealed the assistants completed the Activities Assessments and the Activities Director placed the activities interventions on the Comprehensive Care Plan. Since the Activities Director had been on leave, an activities employee from another facility had assisted in getting the activities on the care plans in the computer. The Administrator supervised the Activities Assistants while the Activities Director was on leave. Activities Assistant #2 reviewed the care plan and activities plan for Resident #7 and stated she was unaware Resident #7 should have received 1:1 activities.</p> <p>Interview with the Administrator, on 12/17/15 at 1:12 PM, revealed he was unaware of the issue with Resident #7 not receiving 1:1/social activities from the Activities Department per the resident's plan of care.</p> <p>The facility provided an acceptable credible</p>	F 282	INTENTIONALLY LEFT BLANK	



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F 282	<p>Continued From page 37</p> <p>Allegation of Compliance (AOC) on 12/23/15 and took the following actions to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> <li>1. Upon Resident #29's return to the facility, a total body audit was conducted by LPN #12 with no injuries found.</li> <li>2. The resident was placed on one-on-one supervision until the resident was moved to a secure locked unit.</li> <li>3. The Administrator was notified of the incident on 12/16/15 at 6:10 AM, Director of Nursing at 6:00 AM, the resident's physician, who is also the Medical Director, was notified of the incident on 12/16/15 at 6:15 AM with family notification at 6:30 AM.</li> <li>4. LPN #12 conducted an Elopement Evaluation that reflected an actual elopement.</li> <li>5. The facility conducted a visual validation of all residents. All 175 residents were present inside the facility.</li> <li>6. The Maintenance Director checked all egress doors, on 12/16/15 at 8:00 AM, and found all door alarms were working properly in relation to secure locks, Wander Guard alarms, and audible alarms. After the test at approximately 8:30 AM, The Maintenance Director reset all mag locks with a new exit code. All door codes would be changed monthly for six (6) months. Entrance B's door alarm activated when the resident was returned to the building. The resident's Wander Guard device was found to be working.</li> <li>7. The Director of Nursing conducted staff</li> </ol>	F 282	INTENTIONALLY LEFT BLANK	

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F 282	<p>Continued From page 38</p> <p>interviews with staff working at the time of the elopement. LPN #12 voiced hearing the door alarm sounding at approximately 5:30 AM. No other staff voiced they heard the alarm. No staff witnessed Resident #29 exit the facility.</p> <p>8. On 12/17/15, all one hundred seventy-six (176) residents were reassessed for elopement risk by using the Elopement Risk Evaluation form. Thirty-three (33) residents were assessed to be at risk for elopement. These residents' care plan and Kardex were reviewed and updated as indicated.</p> <p>9. An Ad-hoc Quality Improvement Committee meeting was held on 12/16/15 to review the Elopement and Care Plan Policy, no changes were made.</p> <p>10. Staff re-education began on 12/16/15 and was completed on 12/21/15. The education included the facility's Elopement Policy, staff response to a door alarm, different door alarm sounds, routine and Wander Guard. The facility staff and housekeeping contract employees were instructed that door codes were not to be given to any visitor, family member, or vendor. Staff would assist all visitors out the exit doors. Each employee completed a post-test to validate learning and must score a 95%.</p> <p>11. Written education regarding each alarm sound was placed at each nurses' station for continuous staff reference.</p> <p>12. All egress exit door codes were changed on 12/16/15 and staff will have to assist visitors when exiting the center. A sign was placed on each exit doors stating "Please be mindful that no resident</p>	F 282	INTENTIONALLY LEFT BLANK	

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F 282	<p>Continued From page 39 of the facility is exiting with you." After hours, Entrance B doors would be locked at 7:00 PM and unlocked at 8:00 AM.</p> <p>13. A letter was mailed to residents' families to notify them of the new security measures. A letter was mailed to all vendors, Emergency Medical Services, and physicians informing them the door codes would no longer be given out and requesting attention of security when entering and exiting the facility.</p> <p>14. Elopement drills were conducted on each shift through 12/21/15 for audit training compliance.</p> <p>15. The Wander Guard devices would be checked every shift and documented on the Treatment Administration Record. All Wander Guards devices were checked and found to be working properly.</p> <p>16. Exit Doors: The Maintenance Department would check the door alarms Monday through Friday with the weekend Administration person on call performing the door checks on the weekends.</p> <p>Entrance B locking system would be audited by the Maintenance Department daily for four weeks.</p> <p>17. An Ad-Hoc Quality Improvement Committee meeting was held on 12/21/15 to review the elopement event and corrective plans. The Medical Director was present. The Quality Improvement Committee will meet monthly for six months or until issues are resolved.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p>	F 282	INTENTIONALLY LEFT BLANK	

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F 282	<p>Continued From page 40</p> <ol style="list-style-type: none"> <li>Review of the Electronic Record, dated 12/16/15 at 7:16 AM, revealed a physical assessment was conducted with vital signs taken and recorded to be within normal range for the resident. The record revealed the resident's primary physician assessed the resident on 12/16/15 at 3:05 PM that included all body systems. No injuries were noted.</li> <li>Review of the Electronic Record revealed the resident was placed on one-on-one supervision after returned to the facility and transferred to the secure unit at 4:00 PM. Review of the One-on-One Supervision Sheet, dated 12/16/15, revealed the resident was on one-on-one supervision from 6:00 AM until 5:30 PM</li> <li>Review of a Progress Note, dated 12/16/15 at 7:16 AM, validated the notification.</li> <li>Review of the Elopement Evaluation conducted on 12/16/15 revealed the resident remained at risk for elopement.</li> <li>Review of the census count revealed one hundred seventy-five (175) were present in the facility at the time of the count. Interview with the DON, on 12/30/15 at 8:59 AM, revealed a complete head count was conducted after the resident was returned to the building and all residents were present.</li> <li>Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, revealed he had checked all exit doors and found all alarms were working properly on the day of the elopement. He stated he changed the code to all mag lock exit doors that day and would be changing the door codes monthly for at least six (6) months. Interview with</li> </ol>	F 282	INTENTIONALLY LEFT BLANK		

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F 282	<p>Continued From page 41</p> <p>Certified Nursing Assistant (CNA) #8 on 12/17/15 at 4:23 PM and LPN #12 on 12/17/15 at 6:14 PM, validated the resident's Wander Guard device activated the door alarm when the resident was returned to the building.</p> <p>7. Review of the facility's investigation revealed twelve (12) staff was interviewed and only one recalled hearing the door alarm. No staff witnessed the resident leave the building.</p> <p>8. Review of the Elopement Risk Evaluation forms revealed the facility had assessed one hundred seventy-six (176) residents. Validated thirty-three (33) residents were identified at risk for elopement. These residents' photo and information was placed in an Elopement Binder at each unit. Review of the residents' Kardex revealed all thirty-three (33) residents were updated and Care plans of the residents at risk had been reviewed and updated as needed. Review of sampled Residents #30, 31, 32, 33, 34, 35, 36, and 37 during the extended survey revealed the residents care plans had been updated, their pictures were in the Elopement Binder, and information on the Kardex.</p> <p>9. Review of the Elopement Policy and Care Plan Policy revealed no changes. Review of the sign in sheet for the meeting revealed the meeting was held on 12/15/15 as stated.</p> <p>10. Review of the training records revealed all active employees received the training with post-test given.</p> <p>Validation of training interviews were conducted on 12/28/15 with CNA #10 at 2:04 PM, Unit Manager of Homestead at 2:15 PM, LPN #13 at</p>	F 282	<p><b>INTENTIONALLY LEFT BLANK</b></p>	

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F 282	<p>Continued From page 42</p> <p>1:30 PM, CNA #19 at 3:16 PM, and CNA #20 at 3:24 PM. The staff stated they had received training on the Elopement Policy and what to do when a door alarm sounded. The staff had good knowledge of the process and stated they had to take a post-test and score 95%.</p> <p>On 12/29/15, the following staff were interviewed regarding the training they received: CNA #7 at 9:07 AM, CNA #11 at 9:12 AM, CNA #12 at 9:14 AM, CNA #13 at 9:30 AM, CNA #4 at 9:41 AM, CNA #14 at 3:19 PM, CNA #15 at 3:04 PM, CNA #18 at 9:25 AM, CNA #17 at 3:07 PM, CNA #18 at 3:23 PM, CNA #19 at 3:16 PM, and CNA #20 at 3:24 PM. The staff was knowledgeable of the facility's Elopement Policy and what to do if the door alarm was activated. They were required to take a post-test and score 95%.</p> <p>Interviews conducted on 12/29/15 with Licensed Practical Nurse (LPN) #1 at 9:02 AM, LPN #14 at 9:05 AM, LPN #9 at 9:28 AM, LPN #15 at 9:25 AM, #9 at 9:42 AM, LPN #17 at 2:28 PM, and LPN #16 at 2:35 PM revealed they had received re-education on the Elopement Policy, they are responsible for checking the Wander Guard devices three (3) times a day and record the checks on the Treatment Administration Record (TAR). In addition, care planning was reviewed.</p> <p>Interview with the Unit Manager of Homestead, on 12/28/15 at 2:15 PM, and NF1 Unit, on 12/29/15 at 10:30 AM, revealed training was provided to them and a post-test was required. The Managers are responsible for audits of the TAR and to ensure the nurses are checking the Wander Guard devices.</p> <p>Interview with Housekeeper #1, on 12/29/15 at</p>	F 282	<p><b>INTENTIONALLY LEFT BLANK</b></p>	

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F 282	<p>Continued From page 43</p> <p>9:17 AM, and Housekeeper #2 on 12/29/15 at 9:00 AM, revealed the facility provided training for all contract housekeeping staff regarding the facility's Elopement Policy and what to do when a door alarm sounded.</p> <p>Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, and the Maintenance Assistant, on 12/29/15 at 8:34 AM, revealed they received training on the Elopement Policy and door alarms. They took the post-test also.</p> <p>Interview with the Staff Educator, on 12/29/15 at 4:26 PM, revealed she had provided most of the training. She stated she conducted most training in small groups. She stated she developed talking points for the elopement and care plan education. These talking points were the bases for the post-test that each employee was required to take. She stated the education included door codes not to be given out to anyone that was not an employee of the facility and door alarms and how to respond.</p> <p>11. Observation on 12/28/15 at 1:05 PM, revealed posting of the written education on all four units.</p> <p>12. Observations during the extended survey revealed facility assisting visitors when exiting the building including surveyors on 12/28/15 through 12/30/15. Observation upon entrance to the facility on 12/28/15 at 11:05 AM revealed the sign was posted at the Entrance A doors and observation at 11:20 AM revealed the sign was posted on the Entrance B doors and the Homestead Unit doors.</p> <p>Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, revealed a new timer was</p>	F 282	INTENTIONALLY LEFT BLANK		

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F 282	<p>Continued From page 44</p> <p>placed on the Entrance B keypad to lock the doors from 7:00 PM to 8:00 AM. He stated a visitor will have to ring a bell and staff will have to go to the door to let the person in. When the visitor is ready to leave the building, staff would assist by opening the door, using the coded keypad.</p> <p>13. Review of the letters, dated 12/21/15, revealed letters were sent to the vendors, families, and physician notifying them of the new security measures.</p> <p>14. Review of the audits revealed the elopement drills were conducted as stated. Audits will be reviewed during the morning meeting to ensure the audits were completed.</p> <p>Interview with the Director of Nursing, on 12/30/15 at 8:59 AM, revealed elopement drills were conducted and the audits were discussed during the morning meetings.</p> <p>15. Observation of a Wander Guard device check, on 12/28/15 at 1:27 PM, in the Homestead Secure Unit, revealed all residents' Wander Guard devices were applied and functioning properly.</p> <p>Review of the TAR revealed the facility had increased the Wander Guard device checks to three (3) times a day, where the checks were previously twice a day. Review of all residents with a Wander Guard device revealed the checks were being done.</p> <p>Interview with the Unit Manager of Homestead, on 12/28/15 at 2:15 PM, and NF1 Unit, on 12/29/15 at 10:30 AM, revealed the Unit</p>	F 282	<p><b>INTENTIONALLY LEFT BLANK</b></p>	
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F 282	<p>Continued From page 45</p> <p>Managers are responsible for audits of the TAR to ensure the nurses are checking the Wander Guard devices.</p> <p>16. Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, revealed all exit doors were checked daily. Observation on 12/29/15 at 8:34 revealed the Maintenance Assistant tested all exit doors in the Homestead Unit. All doors were functioning properly.</p> <p>Review of documentation revealed the new key pad was installed on 12/29/15. The Entrance B locking system was audited daily. Review of the door audits revealed no problems found.</p> <p>17. Review of the Quality Improvement Meeting on 12/21/15 revealed all members present including the Medical Director.</p> <p>Interview with the Administrator, on 12/30/15 at 8:02 AM, revealed the Ad-Hoc meetings are additional meetings between the official Quality Assurance meetings scheduled monthly. The Quality Improvement meeting held on 12/21/15, with the Medical Director in attendance, was to review the AOC and review any audits to that date. The next scheduled Quality Improvement meeting is scheduled for 01/17/16. The Administrator stated audits would be reviewed at each meeting until compliance is achieved.</p> <p>Interview with the Medical Director, on 12/30/15 at 9:42 AM, revealed he was present at the Quality Improvement meeting held on 12/21/15. He stated he was involved in the development of the AOC as the facility asked for his input. The facility discussed the corrective actions and the committee approved the audit tools. He stated the</p>	F 282	INTENTIONALLY LEFT BLANK		

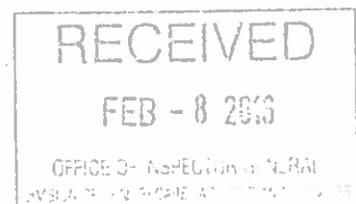
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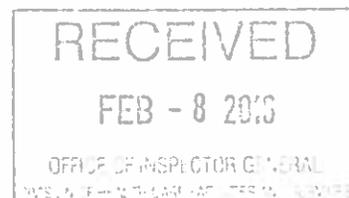
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F 282	Continued From page 46 facility had notified him of the Immediate Jeopardy and informed him of the details and the action plans that had been implemented. He stated he was committed to attending the next Quality Improvement meeting scheduled for 01/07/16.	F 282	F 309	
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to follow physician orders for two (2) unsampled residents, Unsampled Residents L and M. Licensed Practical Nurse (LPN) #8 failed to administer Buspar (anti-anxiety) and Gabapentin (anti-convulsant) to Unsampled Resident M. The facility could not identify the nurse who signed the pharmacy receipt for Tramadol (narcotic) that was sent to the facility for Unsampled Resident L.</p> <p>The findings include: Review of the facility's policies on Pharmacy Services, revised 03/01/11, Medication</p>	F 309	<p>1. The physician was notified for resident L and M on December 16, 2015 by the Director of Nursing. The Buspar and Gabapentin were transcribed on the Medication Administration Record and administrated at the next scheduled dose. The Tramadol was removed from the medication cart by the Unit Manager on December 16, 2015 following physician notification by the Unit Manager. Neither resident experienced any negative outcome. LPN #8 and #7 were re-educated on medication transcription by the Unit Manager on December 16, 2015.</p> <p>2. All residents of the facility have the potential to be affected. On December 28, 2015 the Unit Manager conducted an audit of current residents' physicians' orders since December 1, 2015 to ensure that the orders were taken off appropriately, medications ordered from the pharmacy and transcribed to the Medication Administration Records (MAR) with corrective action upon discovery.</p>	2/13/16



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/30/2015	
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
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F 309	<p>Continued From page 47</p> <p>Administration Policy, revised 07/01/15, and Receipt of Routine Deliveries Policies, revised 12/15/08, revealed there was no instruction or direction regarding how to or when a nurse should place orders onto the Medication Administration Record.</p> <p>1. Observation of Unsampled Resident M's medication pass, on 12/16/15 at 9:40 AM, revealed Licensed Practical Nurse (LPN) #8 did not administer Buspieronone 30 milligrams (mg) or Gabapentin 600 mg during her morning medication pass.</p> <p>Review of Unsampled Resident M's Physician Orders, dated 12/11/15 at 11:30 AM, revealed an order for Buspar 30 mg twice a day (for anxiety), Gabapentin 300 mg at 2:00 PM, and Gabapentin 300 mg, two (2) in the morning and two (2) at night (for nerve pain).</p> <p>Observation of the Medication Cart, on 12/16/15 at 9:40 AM, revealed both Buspar 30 mg and Gabapentin 300 mg were available in the Medication Cart.</p> <p>Review of Unsampled Resident M's Medication Administration Record (MAR) for the month of December 2015, revealed the staff did not administer the Buspar or the Gabapentin medication on 12/11/15, 12/12/15, 12/13/15, 12/14/15 or 12/15/15 and administered the first dose on 12/16/15 in the evening which was approximately five (5) days after the medication was ordered.</p> <p>Interview with LPN #8, on 12/16/15 at 9:20 AM, revealed when the nurses obtained a telephone order, the nurses would place the order into the</p>	F 309	<p>A Medication Administration Record comparison to medication cart audit was conducted by a pharmacy representative on December 28, 2015 to ensure that medications without a current physician's orders were returned to the pharmacy or disposed of appropriately on December 30, 2015. Areas of concern were corrected upon discovery.</p> <p>3. A Pharmacy representative and or Nurse Practice Educator re-educated licensed nurses regarding the need to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care including the process of ordering, transcribing medications to the MAR and/or returning medications and the process of printing Medication Administration Record following the receipt of a physician's order on January 19, 2016. A post-test was conducted at the time of the re-education with a passing score of 95% graded by the Director of Nurses or Nurse Practice Educator to validate</p>	2/13/16



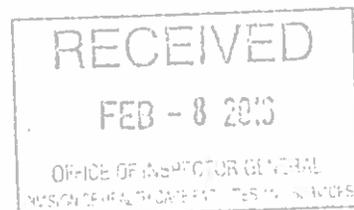
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F 309	<p>Continued From page 48</p> <p>computer, print out the order and fax the order to pharmacy. The nurses were not directed to write the order on the MAR, but to print out the order from the computer and place the printed order on the MAR. LPN #8 stated it appeared LPN #7 (who initialed the order) did not print out the order to place on the MAR, nor did she place the printed order in the doctor's folder for review.</p> <p>Interview with LPN #7, on 12/17/15 at 10:15 AM, revealed LPN #7 obtained the telephone orders for Unsampled Resident M's Buspar and Gabapentin. She remembered putting the order into the computer and faxing the order to the pharmacy. LPN #7 stated she thought she had placed the printed order on the MAR for the administration. LPN #7 stated she also remembered placing the order in the doctor's folder for signature. LPN #7 stated when there was an order the nurses were not directed to write the order on the MAR, but to print out the order from the computer. LPN #7 stated the night nurses should have found the discrepancy through their nightly chart check. LPN #7 stated if Unsampled Resident M did not receive the medication Buspar or Gabapentin the resident could continue to suffer from pain and anxiety.</p> <p>Interview with the Unit Manager of the Transitional Care Unit (TCU), on 12/16/15 at 9:30 AM, revealed once the nursing staff placed an order in the computer, the nurses were to fax the order to pharmacy, place one (1) copy on the MAR and one (1) copy in the doctor's book to be signed. The Unit Manager of the TCU stated during the morning meetings she would print out a document which would have all of the orders that were received the prior day. She stated she would then go to the resident's chart to ensure</p>	F 309	<p>understanding of the information presented. Staff not available during this timeframe including new hires with orientation will complete reeducation with a posttest by the Director of Nurses or Nurse Practice Educator to validate understanding upon return to work.</p> <p>The Director of Nursing, Pharmacy Representative and or the Unit Managers will audit across all shifts new medication orders, to ensure medications are transcribed to the Medication Administration records and medications are administered as per physician order daily times 14 days including weekends then 3 times per week times 2 weeks then weekly times 8 weeks then biweekly times 8 weeks then monthly times 1 month. Medication carts will be audited for medications returned to the pharmacy or disposed of appropriately when discontinued weekly times 8 weeks, bi-weekly times 8 weeks, monthly times 2 months. Areas of concern will be corrected upon discovery.</p>	2/13/16



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F 309	<p>Continued From page 49</p> <p>the order was placed on the MAR or Treatment Administration Records (TAR). The Unit Manager of the TCU stated she did not remember seeing the order and to be honest she had eight (8) admissions the day of 12/11/15 and was busy, so she did not have the opportunity to check the orders against the resident's records.</p> <p>Interview, on 12/17/15 at 9:11 AM, with the Supervisor who worked on 12/11/15, revealed she was acting as the Director of Nursing (DON) and was responsible for the morning meeting on that day. The Supervisor stated during the morning meetings, the team would not look at every order, just the orders that showed a change of condition. The Supervisor stated it was the responsibility of the Unit Managers to ensure orders were placed in the doctor's folder for review and to ensure the orders were taken off and placed on the MAR. The Supervisor stated she remembered the TCU receiving many admissions on 12/11/15. She stated the resident not receiving his/her medication was a breakdown in their process and could be serious. The Supervisor stated it was the responsibility of the DON to ensure the Unit Managers were completing their tasks. She stated she expected the staff to follow the physician orders.</p> <p>Interview with the DON, on 12/16/15 at 9:45 AM, revealed the Supervisor was present in her absence on 12/11/15. The DON stated during the morning meetings the staff would go over the orders and the Unit Managers were responsible to verify that the orders were taken off appropriately.</p> <p>2. Inspection of the Nursing Facility 1 (NF1) medication carts, on 12/16/15 at 11:10 AM,</p>	F 309	<p>4. The Director of Nursing and or Unit Managers will submit a summary of the audit findings monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p>	2/13/16	

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F 309	<p>Continued From page 50</p> <p>revealed Unsampled Resident L had a medication blister pack of thirty (30) tablets of Tramadol (Scheduled II narcotic) 50 mg ordered to be given routinely every eight (8) hours and was available for use. Review of the Tramadol blister pack, revealed the order was prescribed on 11/11/15 by the physician, but had never been administered. All thirty (30) tablets were available for use. The Tramadol medication had been logged into the narcotic book as received.</p> <p>Review of the clinical record for Unsampled Resident L, revealed the facility admitted the resident on 02/27/10 with diagnosis of Hemiplegia and Hemiparesis, Primary Generalized Osteoarthritis, Difficulty Walking, Full Incontinence of Feces, Urinary Incontinence, Unspecified Cerebrovascular Disease, Dementia without Behavioral Disturbance and Pain in Unspecified Limb.</p> <p>Review of Unsampled Resident L's Medication Administration Record (MAR), dated December 2015 revealed the Tramadol 50 mg had not been transcribed onto the MAR.</p> <p>Review of Unsampled Resident L's Physician Orders, revealed there was no physician order located in Unsampled Resident L's chart for the Tramadol 50 mg to be administered.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/16/15 at 4:50 PM, revealed she thought that the pharmacy made a mistake and sent the Tramadol 50 mg without an order. LPN #3 continued to explain that the medication should have been sent back to the pharmacy. She stated the facility's process for receiving medications would be for the nurse to sign for the medication,</p>	F 309	<p><b>INTENTIONALLY LEFT BLANK</b></p>	

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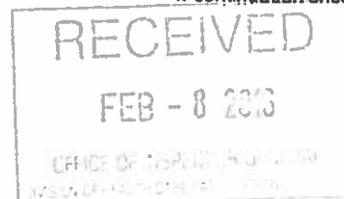
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F 309	<p>Continued From page 51</p> <p>then count the medication, place the medication into the medication cart, assign a page in the narcotic book and to date the medication. LPN #3 stated the nurse failed to follow-up with the physician and the pharmacy about the received narcotic. Further interview revealed the nurse failed to clarify the prescription with the physician and the pharmacy. The Tramadol 50 mg, 30 tablets, had been stored in the medication cart since 11/11/15, the day the medication was received.</p> <p>Interview, on 12/17/15 at 9:45 AM, with the Unit Manager of NF1 revealed she was aware there was no order in the physical or electronic chart for Unsamped Resident L. She continued to state that the prescribing physician was not Unsamped Resident L's Primary Care Physician and she did not know how the order was received.</p> <p>Interview with the Director of Nursing (DON), on 12/17/15 at 9:45 AM, revealed if a nurse on a unit had been aware there was no order for a medication, or a narcotic, the nurse should have informed her about it and she would have followed up with the medication discrepancy.</p> <p>Interview with the Pharmacist, on 12/16/15 at 5:12 PM, revealed an order had been received. The pharmacy faxed the physician prescription order to the facility. Review of the prescription revealed it was written and signed by a physician. Further interview with the Pharmacy Representative, on 12/17/15 at 10:55 AM, revealed a delivery slip had been signed by a nurse at the facility and the medication was</p>	F 309	<p style="text-align: center;">NTENTIONALLY LEFT BLANK</p>	

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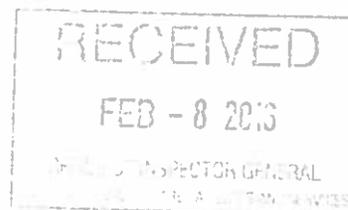
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F 309	Continued From page 52	F 309	F 312		
F 312 SS=D	delivered on 11/11/15 for Unsampled Resident L. However, after review of the delivery slip, the facility could not identify the nurse's signature. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene related to receiving assistance with bathing for one (1) of thirty-seven (37) sampled residents (Resident #9).  The findings include:  Review of the facility's policy regarding Activities of Daily Living (ADL): Shower, dated 12/01/06, revealed a shower would be provided to residents who wish to participate. Showers were to be given according to a pre-determined schedule and as needed or requested. In addition, facility staff would document showers and personal care.  Review of the facility's policy regarding Activities of Daily Living (ADL) Documentation, dated 05/04/15, revealed ADL assistance would be documented on the ADL Flow Record or in the	F 312	1. Resident #9 received a shower on December 15, 2015, a body audit was conducted by the licensed nurse and no skin issues were identified. Resident #9 did not experience any negative outcome.  2. All residents of the facility have the potential to be affected. On December 15, 2015 the Director of Nursing Services and or Unit Managers conducted an audit of all residents bathing records to ensure showers/baths were completed a minimum of two per week and/or per resident choice with corrective action upon discovery.  3. The Director of Nursing Services or Nurse Practice Educator will reeducate licensed and certified nursing staff on or before 2/12/16 regarding the need to ensure residents received the necessary services to maintain good personal hygiene including preferred shower/bath schedule with a posttest to validate understanding with a passing score of 95% graded by the Director of Nurses or Nurse Practice Educator. Staff not	2/13/16	



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F 312	<p>Continued From page 53</p> <p>Point Click Care (PCC) ADL Point of Care (POC) by the end of the shift.</p> <p>Review of Resident #9's clinical record, revealed the facility admitted the resident on 07/08/15 with diagnoses of Congestive Heart Failure, Gastric Cancer, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Hypertension, Gastroesophageal Reflux Disease, Obesity, Muscle Weakness, Chronic Pain, Depression, Insomnia, Anxiety, Neuropathy, and Osteoarthritis.</p> <p>Review of Resident #9's Quarterly Minimum Data Set (MDS), dated 10/15/15, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) of a fifteen (15) and determined the resident was interviewable. In addition, the facility assessed Resident #9 as totally dependent on staff for bathing, and required a one person physical assistance with bathing.</p> <p>Review of the Nursing Facility (NF1) Shower Schedule, revealed Resident #9 was to get a shower every Tuesday and Friday on the first shift.</p> <p>Review of Resident #9's ADL Record for December 2015, revealed from 12/03/15 to 12/11/15, the resident did not receive a bath, shower, or a sponge bath.</p> <p>Review of the Weekly Bath and Skin Report for Resident #9, revealed he/she received a bath/shower on 12/02/15, 12/08/15, and 12/15/15. However, Resident #9 did not receive a shower/bath on 12/04/15 or 12/11/15, which were the designated shower days for the resident.</p>	F 312	<p>available during this timeframe including new hires with orientation will complete reeducation with a posttest by the Director of Nurses or Nurse Practice Educator to validate understanding upon return to work.</p> <p>The Director of Nursing and or Unit Managers will audit shower documentation to ensure bathing is provided according to resident preference daily x 2 weeks including weekends, then three times a week x 2 weeks, then every other week x 3 weeks then monthly time 1 month with corrective action/reeducation upon discovery.</p>	2/13/16



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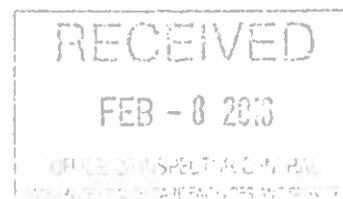
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F 312	Continued From page 54  Review of Resident #9's progress notes from 12/04/15 through 12/11/15, revealed no documentation that baths/showers were given on 12/04/15 or 12/11/15.  Observation of Resident #9, on 12/15/15 at 12:45 PM, revealed the resident was laying in bed on his/her back, dressed in a hospital gown. Resident #9's hair was greasy, and matted to his/her head.  Interview with Resident #9, on 12/15/15 at 5:05 PM, revealed he/she was not getting showers or bed baths consistently and on average he/she was given a shower or bed bath only once per week. Resident #9 stated it made him/her feel bad when he/she wasn't clean.  Interview with CNA #4, on 12/16/15 at 12:15 PM, revealed Resident #9 was dependent on staff for assistance with bathing needs. In addition, CNA #4 stated showers/baths should be documented in the Shower Log and in the ADL book so staff could see what care was provided. In addition, any refusals of care should also be documented.  Interview with the NF1 Unit Manager, on 12/17/15 at 1:25 PM, revealed per facility policy all staff was responsible to help residents complete ADLs and all ADL care provided should be documented in the clinical record. The Unit Manager stated showers/baths should be given according to a resident's shower schedule, and recorded on the Weekly Bath and Skin Report sheets kept in the NF1 Shower Book. The Unit Manager stated the Weekly Bath and Skin Report revealed there was a gap in ADL care for Resident #9 and he/she should have received a shower/bath on 12/4/15	F 312	4. The Director of Nursing and or Unit Manager will submit a summary of the audit findings monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow-up and or in-servicing needs until the issue is resolved and ongoing thereafter.	2/13/16
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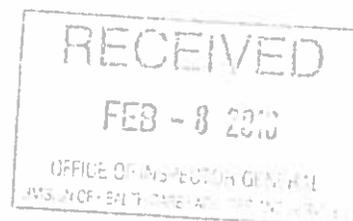


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F 312	Continued From page 55 and 12/11/15, but did not. The NF1 Unit Manager stated bathing was a basic need for all residents, and the facility was not meeting Resident #9's bathing needs. In addition, the NF1 Unit Manager stated failing to provide baths/showers was not helping a resident to achieve his/her highest practicable well-being.	F 312		
F 323 SS-J	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, record review and review of the facility's elopement policy, it was determined the facility failed to have an effective system to ensure adequate supervision of residents with known behaviors of wandering for one (1) of thirty-seven (37) sampled residents	F 323	F323  1. Resident # 29 was re-assessed by a Licensed Nurse on 12/16/2015. A head to toe assessment was completed, vital signs were taken, resident was placed on 1 on 1 observation the elopement assessment was reviewed and updated to reflect an actual elopement. The resident was transferred to Regis Woods Alzheimer's nursing unit on 12/16/2016 and the care plan was updated to reflect resident's current status. The Physician, who is also the Medical Director, was notified at approximately 6:15AM and Responsible Party was notified at approximately 6:30AM on 12/16/15 by LPN #12. The DNS and Administrator were notified on 12/16/15 by LPN #12 at 6:10AM. On 12/16/15 the Physician completed an assessment on Resident #29 and determined the resident did not experience any negative outcome.	2/13/16

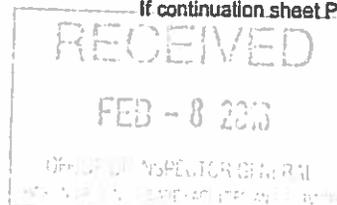


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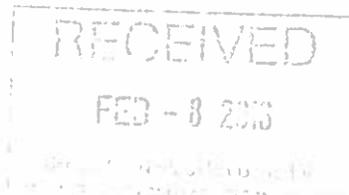
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F 323	<p>Continued From page 56</p> <p>(Resident #29). The facility assessed Resident #29 to have elopement tendencies due to the resident's history. The facility initiated a Comprehensive Care Plan to address the resident's risk for elopement with a goal the resident would not wander from a secure environment and the resident would be observed for potential triggers to wandering. A Wander Guard device was applied to alert the staff when the resident attempted to elope from the facility.</p> <p>On 12/16/15, at approximately 5:35 AM, Resident #29 exited the facility without staff knowledge. The resident was found off the facility's grounds, walking down the middle of a busy road with a rolling walker, with two cars from opposite directions blinking their lights to avoid hitting the resident. The resident was returned to the facility at 6:20 AM without harm. The resident's Wander Guard device activated the door's alarm when the resident walked back into the building. The facility's investigation determined the door alarm was activated and staff failed to respond according to facility policy. The staff failed to search the area (including looking outside) where the door alarm was activated and failed to ensure all residents were present.</p> <p>The facility's failure to provide adequate supervision of a resident with known wandering risk placed those residents in a situation that has caused or is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care (SQC) was identified on 12/18/15 and determined to exist on 12/16/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 12/23/15 which alleged removal of the Immediate Jeopardy on 12/22/15.</p>	F 323	<p>2. All residents of the facility have the potential to be affected. Upon notification of the elopement, RN &amp; LPN charge nurses immediately completed a visual validation census check. All 175 residents were present inside the facility. This was initiated at 5:55AM by the licensed nurse.</p> <p>176 residents residing in the center were reviewed by the RN and LPN nurses on 12/17/15 to identify elopement risk. 176 Elopement Risk Evaluations for at risk residents were reviewed, 33 of 33 care plans were reviewed and updated and 33 of 33 Kardexes were reviewed and updated as indicated by the licensed nurse upon discovery. No additional residents were identified as an elopement risk. There have been no additional elopements since 12/16/16.</p> <p>Staff re-education was immediately initiated by the Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator or</p>	2/13/14



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F 323	<p>Continued From page 57</p> <p>The State Survey Agency verified Immediate Jeopardy was removed on 12/22/15 as alleged, prior to exit on 12/30/15. The Scope and Severity was lowered to a "D" while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Elopement of Residents, revision date of 05/15/14, revealed all residents would be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing assessment process. Those determined to be at risk for elopement would receive appropriate interventions to reduce risk and minimize injury. The policy detailed elopement occurred when a patient left the premises without authorization or necessary supervision. For those residents identified at risk, an interdisciplinary elopement prevention care plan would be developed with individual risk factors and patterns identified and addressed within the care plan. All staff would be trained on the facility's door security system and required to respond to a sounding alarm.</p> <p>Interview with the Administrator, on 12/17/15 at 10:32 AM, revealed Resident #29 had left the building at approximately 5:45 AM on 12/16/15 without staff's knowledge. He had been told the resident had exited the building from Entrance B and was found on the grass beside the road in front of the facility. An employee, who was sitting in his car in the front parking lot, saw the resident and returned the resident back into the building through the same exit doors. The employee had</p>	F 323	<p>Administrator beginning on 12/16/15 with completion on 12/21/15. 205 employees in facility, which includes 5 agency Dietary staff and 16 agency Housekeeping/Laundry staff with received the education and training the same as facility staff. 171 employees completed the education.</p> <p>Re-education included:</p> <ul style="list-style-type: none"> <li>• Center policies on elopement prevention &amp; management.</li> <li>• Expected employee response to a door alarm.</li> <li>• Different sounds of door alarms: routine and wanderguard</li> <li>• All egress exit door codes will be changed monthly.</li> <li>• Egress exit door codes are not to be released to any visitor or vendor.</li> <li>• Staff will assist all visitors to exit the center.</li> <li>• Signs on visitor exit doors will be placed to be seen whether entering or exiting,</li> </ul>	2/13/16



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F 323	<p>Continued From page 58</p> <p>told the Administrator the resident's Wander Guard device had activated the door alarm when the resident walked through the doors, indicating the door alarms were functioning. He stated the resident ambulated independently with a rolling walker; however, was cognitively impaired and was assessed by the facility as a elopement risk. He stated the resident was assessed and found with no injuries. The resident had been placed on one-to-one supervision until the resident was transferred to the secure unit (Homestead). He stated he was in the process of interviewing the staff and had not completed his investigation at this time.</p> <p>Review of the clinical record for Resident #29 revealed the resident had resided at the facility since 07/17/13. Review of the most current diagnoses included: Dementia, Muscle Weakness, Abnormal Posture, Hypothyroidism, Depression, and Anxiety Disorder. Review of the Annual MDS Assessment, dated 05/02/15, and the Quarterly Minimum Data Set (MDS) Assessment, dated 10/20/15 revealed the facility assessed the resident to have a severe cognition loss with a Brief Interview for Mental Status (BIMS) score of three (3) out of possible fifteen (15). The facility assessed the resident to require minimum assistance from staff with ambulation (with a walker) in the room and outside in the corridor. The facility assessed the resident to require extensive assistance with bed mobility and transfers.</p> <p>Review of the comprehensive care plan, revised 12/17/15, revealed a care plan was developed on 05/14/15 for risk of elopement related to the resident's cognition loss and diagnosis of Dementia. The care plan stated the resident</p>	F 323	<p>Stating "Please be mindful that no resident of the facility is exiting with you"</p> <ul style="list-style-type: none"> <li>• Need to follow each resident's care plan and Kardex regarding potential for elopement with the interventions for resident safety.</li> <li>• Each employee completed a post-test to validate learning. This grading was completed by the Nurse Practice Educator, Director of Nursing, or Assistant Director of Nursing or administrator between 12/16/15 - 12/21/15 with no employee working without a passing score.</li> </ul> <p>Active employees completed re-education and posttest to validate understanding between 12/16/15 - 12/21/15. All employees scheduled to work on the dates of 12/16/15 through 12/21/15 received education prior to or during the shift.</p>	2/13/16	

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F 323	<p>Continued From page 59</p> <p>would wander and exit seek. The goal was for the resident not to leave the building without an escort. The interventions implemented on 05/14/15 included: to encourage independence while in the building, but ensure supervision while outside; educate staff of elopement potential, triggers, and prevention measures; and, if unable to redirect resident, stay with the resident and provide support and supervision. On 11/09/15, the care plan was revised to include a Wander Guard device with placement and function to be checked. An additional intervention was added on 11/09/15 that instructed staff to document any unsafe wandering and notify the physician and family.</p> <p>Review of the Elopement Evaluation conducted on 11/07/15, revealed the resident had a history of actual elopement or attempted elopement and the resident had expressed the desire to leave. In addition, the evaluation assessed the resident to exhibit behaviors that may result in exit-seeking behaviors to include: hovering near exits, impulsive, and restless. However, the Elopement Evaluation did not include a summary of the findings and did not state what interventions the facility would implement.</p> <p>Review of a progress note, dated 12/16/15 at 7:16 AM, revealed Resident #29 was last seen at 5:20 AM on the unit by LPN #12. The resident was reported being outside the facility at 5:45 AM. The resident was transferred to the secure unit at 5:38 PM.</p> <p>Interview with Licensed Practical Nurse (LPN) #12, on 12/17/15 at 6:14 PM, revealed he worked Nursing Facility 2 (NF2) Unit and was responsible for Resident #29 the morning the resident eloped</p>	F 323	<p>Employees not available during this time period and not scheduled through 12/21/15 were contacted via telephone by each employee's immediate supervisor to be made aware that reeducation with post-tests will be required prior to the next scheduled shift. New employees will receive education including posttest during orientation including any new agency staff. Learning will be validated at the time of completion with a passing score of 95% by the Nurse Practice Educator, Director of Nursing, or Assistant director of Nursing or Administrator.</p> <p>As of 12/16/15 the Administrator, Assistant Administrator and/or Director of Nursing have assigned designated audits to the administration and management staff during morning meeting to ensure that the audits are completed. The audits continue to be reviewed in morning meeting and during Quality Improvement Committee (QIC) meetings for completeness and corrective action upon discovery.</p>	2/13/16	

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F 323	<p>Continued From page 60</p> <p>from the building. He stated he did not see the resident leave the unit. The resident was up and dressed and talking about his/her family leaving them here. He said he was in the middle of medication pass when he heard a door alarm sound. He said he was going to check the alarming door, but before he could lock his medication cart, it had stopped. He stated he went back to passing medications and failed to check the alarming door. He said he could not see Entrance B exit doors from the NF2 Unit. A little while later, a nurse from NF1 Unit came to him and told him Resident #29 was outside. He ran outside and observed Certified Nursing Aide (CNA #8) and the "Lab Lady" bringing the resident back into the building. He stated the resident's Wander Guard device activated the alarm when she went through the doors. He stated the resident had walked to those exit doors before; however, had not attempted to leave before.</p> <p>Interview with CNA #8, on 12/17/15 at 4:23 PM, revealed he was sitting in his car (warming the car) on the morning of 12/16/15 when he saw two (2) cars flashing their head lights to get each other's attention. He stepped out of the car and saw Resident #29 standing in the middle of the road, at the yellow line, with a rolling walker, between the two (2) cars. The Aide stated he thought at first there must have been an accident. He stated he ran to the resident and attempted to remove him/her from the road. He stated the resident started hitting him and resisting the return to the facility and a "Lab Lady" came to assist him. Once they got to Entrance B, other staff came out to help. He stated he did not see the resident leave the building because his car was parked facing the road and the back of the</p>	F 323	<p>3. Door alarm checks for alarm and wanderguard functionality were checked by the maintenance supervisor or maintenance assistant 5 days per week routinely through 12/15/2015. Beginning 12/16/2015, door checks for alarm and wanderguard functionality will also be checked by an LPN or RN charge nurse, or facility manager (Administrator, Director of Nurses, Assistant Director of Nurses, Nurse Practice Educator, Payroll/Benefits Designee, Business Office Manager, Social Services Director, Admissions Director, Health Information Manager, Food Services Director, Activities Director, Clinical Reimbursement Coordinator, MDS Coordinator, Maintenance Director, or Maintenance Assistant) 7 days per week. Any identified concerns will be reported immediately to the Administrator, Director of Nursing or Maintenance personnel for corrective action upon discovery.</p> <p>Entrance B locking system will be audited by the Maintenance Supervisor, DNS, Administrator, Assistant Administrator, Unit Manager, Charge Nurse or Nurse Practice Educator daily X 4 weeks including weekends,</p>	2/13/16

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F 323	<p>Continued From page 61 car was to the facility's exit doors.</p> <p>A telephone interview with the Laboratory Technician, on 12/29/15 at 3:09 PM, revealed she was in the Nursing Facility on 12/16/15 to draw blood from several residents. She stated she had left the building through Entrance B at approximately 5:50 AM. She had not heard any door alarms sounding at that time. She stated she had gone to her car and then looked up and saw two (2) cars blinking their lights, then saw a male running toward a person at the side of the road. She recognized the person to be Resident #29. She stated the male employee was having a hard time getting the resident to return to the building so she went to help and the resident was fighting the employee. She stated the resident went with them and when they approached Entrance B doors, other staff had come out to help. The resident was assisted back into the building.</p> <p>Further interview with the Administrator, in the presence of the Director of Nursing, on 12/17/15 at 5:57 PM, revealed through his investigation, it was determined facility staff failed to follow the facility's Elopement Policy. The Administrator stated LPN #12 heard the alarm sounding and was going to respond, but then did not hear the alarm, so he did not check to see why the alarm was sounding. He stated that the staff did not respond to the alarm the morning of 12/16/15 at 5:45 AM and did not follow the policy by looking and searching outside for the resident. The Administrator stated the door alarms were functioning properly and someone had silenced the door alarm, but no staff had come forward to admit to disarming the alarm.</p>	F 323	<p>then 3 X a week X 4 weeks, Weekly X 4 weeks and Monthly X 3 months. Additional audits will be determined by the monthly Quality Improvement Committee (QIC). Corrective action and/or re-education will be provided at point of discovery.</p> <p>Care implementation for residents identified to be at risk for elopement upon admission, readmission and/or change in condition will be initiated upon identification of the risk for elopement as determined by the elopement risk evaluation by a licensed practical nurse or registered nurse. These care plans will be reviewed starting on 12/17/15 through the morning clinical meeting process daily Monday to Friday and on weekends by the charge nurse of the unit with corrective action upon discovery.</p>	2/13/16

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F 323	<p>Continued From page 62</p> <p>Observation of the resident during the Extended Survey, on 12/28/15 at 1:06 PM revealed the resident ambulating with a rolling walker on the secure unit. The resident had a Wander Guard bracelet applied to his/her left ankle. Attempts to interview the resident was unsuccessful.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/23/15 and took the following actions to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> <li>1. Upon Resident #29's return to the facility, a total body audit was conducted by LPN #12 with no injuries found.</li> <li>2. The resident was placed on one-on-one supervision until the resident was moved to a secure locked unit.</li> <li>3. The Administrator was notified of the incident on 12/16/15 at 6:10 AM, Director of Nursing at 6:00 AM, the resident's physician, who is also the Medical Director, was notified of the incident on 12/16/15 at 6:15 AM with family notification at 6:30 AM.</li> <li>4. LPN #12 conducted an Elopement Evaluation that reflected an actual elopement.</li> <li>5. The facility conducted a visual validation of all residents. All 175 residents were present inside the facility.</li> <li>6. The Maintenance Director checked all egress doors, on 12/16/15 at 8:00 AM, and found all door alarms were working properly in relation to secure locks, Wander Guard alarms, and audible alarms. After the test at approximately 8:30 AM, The</li> </ol>	F 323	<p>Elopement risk care plans for 5 residents identified at risk for elopement will be audited starting on 12/17/15 by the DNS, ADNS, NPE, CRC, or Administrator for following the care plan implementation and accuracy daily across all shifts X 14 days including weekends, then 5 X per week X 14 days, then no less than 3 X per week for an additional 20 weeks. Additional audits will be determined by the monthly Quality Improvement Committee (QIC). Corrective action and/or re-education will be provided at point of discovery.</p> <p>On 12/16/15 Director of Nurses, Assistant Director of Nurses, or Nurse Practice Educator and/or Maintenance Director will complete an elopement drill on each shift monthly for 3 months then quarterly times 3 quarters or as determined by the monthly Quality Improvement Committee. Corrective action and/or re-education will be provided at point of discovery of identified audit concerns.</p>	2/13/16

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F 323	<p>Continued From page 63</p> <p>Maintenance Director reset all mag locks with a new exit code. All door codes would be changed monthly for six (6) months. Entrance B's door alarm activated when the resident was returned to the building. The resident's Wander Guard device was found to be working.</p> <p>7. The Director of Nursing conducted staff interviews with staff working at the time of the elopement. LPN #12 voiced hearing the door alarm sounding at approximately 5:30 AM. No other staff voiced they heard the alarm. No staff witnessed Resident #29 exit the facility.</p> <p>8. On 12/17/15, all one hundred seventy-six (176) residents were reassessed for elopement risk by using the Elopement Risk Evaluation form. Thirty-three (33) residents were assessed to be at risk for elopement. These residents' care plan and Kardex were reviewed and updated as indicated.</p> <p>9. An Ad-hoc Quality Improvement Committee meeting was held on 12/16/15 to review the Elopement and Care Plan Policy, no changes were made.</p> <p>10. Staff re-education began on 12/16/15 and was completed on 12/21/15. The education included the facility's Elopement Policy, staff response to a door alarm, different door alarm sounds, routine and Wander Guard. The facility staff and housekeeping contract employees were instructed that door codes were not to be given to any visitor, family member, or vendor. Staff would assist all visitors out the exit doors. Each employee completed a post-test to validate learning and must score a 95%.</p>	F 323	<p>4. An adHoc Quality Improvement Committee meeting will be held more frequent when determined by Management and Administration to continue to ensure our plan is effective. The meeting will be with the Administrator, DNS, Admissions Director, Clinical Case Manager, Nurse Practice Educator, and Social Worker. The Medical Director will be notified when an adHoc QIC is conducted via telephone by the Administrator.</p> <p>Door codes will be changed monthly for 6 months starting December 16, 2015 and effectiveness of this plan will be re-evaluated by the Quality improvement committee.</p> <p>Findings will be reviewed with the Quality Improvement Committee (QIC) by the Administrator monthly times 6 months or until the issue is resolved and ongoing thereafter. The QIC committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Admissions and Marketing Coordinator, Activities Director, Social Services Director, Clinical Reimbursement Manager, Maintenance Director, Nurse Practice Educator, Nutrition Services Director and Medical Director.</p>	2/13/16	

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F 323	<p>Continued From page 64</p> <p>11. Written education regarding each alarm sound was placed at each nurses' station for continuous staff reference.</p> <p>12. All egress exit door codes were changed on 12/16/15 and staff will have to assist visitors when exiting the center. A sign was placed on each exit doors stating "Please be mindful that no resident of the facility is exiting with you." After hours, Entrance B doors would be locked at 7:00 PM and unlocked at 8:00 AM.</p> <p>13. A letter was mailed to residents' families to notify them of the new security measures. A letter was mailed to all vendors, Emergency Medical Services, and physicians informing them the door codes would no longer be given out and requesting attention of security when entering and exiting the facility.</p> <p>14. Elopement drills were conducted on each shift through 12/21/15 for audit training compliance.</p> <p>15. The Wander Guard devices would be checked every shift and documented on the Treatment Administration Record. All Wander Guards devices were checked and found to be working properly.</p> <p>16. Exit Doors: The Maintenance Department would check the door alarms Monday through Friday with the weekend Administration person on call performing the door checks on the weekends.</p> <p>Entrance B locking system would be audited by the Maintenance Department daily for four weeks.</p> <p>17. An Ad-Hoc Quality Improvement Committee meeting was held on 12/21/15 to review the</p>	F 323	INTENTIONALLY LEFT BLANK		

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F 323	<p>Continued From page 65</p> <p>elopement event and corrective plans. The Medical Director was present. The Quality Improvement Committee will meet monthly for six months or until issues are resolved.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> <li>1. Review of the Electronic Record, dated 12/16/15 at 7:16 AM, revealed a physical assessment was conducted with vital signs taken and recorded to be within normal range for the resident. The record revealed the resident's primary physician assessed the resident on 12/16/15 at 3:05 PM that included all body systems. No injuries were noted.</li> <li>2. Review of the Electronic Record revealed the resident was placed on one-on-one supervision after returned to the facility and transferred to the secure unit at 4:00 PM. Review of the One-on-One Supervision Sheet, dated 12/16/15, revealed the resident was on one-on-one supervision from 6:00 AM until 5:30 PM.</li> <li>3. Review of a Progress Note, dated 12/16/15 at 7:16 AM, validated the notification.</li> <li>4. Review of the Elopement Evaluation conducted on 12/16/15 revealed the resident remained at risk for elopement.</li> <li>5. Review of the census count revealed one hundred seventy-five (175) were present in the facility at the time of the count. Interview with the DON, on 12/30/15 at 8:59 AM, revealed a complete head count was conducted after the resident was returned to the building and all residents were present.</li> </ol>	F 323	INTENTIONALLY LEFT BLANK		

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F 323	<p>Continued From page 66</p> <p>6. Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, revealed he had checked all exit doors and found all alarms were working properly on the day of the elopement. He stated he changed the code to all mag lock exit doors that day and would be changing the door codes monthly for at least six (6) months. Interview with Certified Nursing Assistant (CNA) #8 on 12/17/15 at 4:23 PM and LPN #12 on 12/17/15 at 6:14 PM, validated the resident's Wander Guard device activated the door alarm when the resident was returned to the building.</p> <p>7. Review of the facility's investigation revealed twelve (12) staff was interviewed and only one recalled hearing the door alarm. No staff witnessed the resident leave the building.</p> <p>8. Review of the Elopement Risk Evaluation forms revealed the facility had assessed one hundred seventy-six (176) residents. Validated thirty-three (33) residents were identified at risk for elopement. These residents' photo and information was placed in an Elopement Binder at each unit. Review of the residents' Kardex revealed all thirty-three (33) residents were updated and Care plans of the residents at risk had been reviewed and updated as needed. Review of sampled Residents #30, 31, 32, 33, 34, 35, 36, and 37 during the extended survey revealed the residents care plans had been updated, their pictures were in the Elopement Binder, and information on the Kardex.</p> <p>9. Review of the Elopement Policy and Care Plan Policy revealed no changes. Review of the sign in sheet for the meeting revealed the meeting was held on 12/16/15 as stated.</p>	F 323	INTENTIONALLY LEFT BLANK	

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F 323	<p>Continued From page 67</p> <p>10. Review of the training records revealed all active employees received the training with post-test given.</p> <p>Validation of training interviews were conducted on 12/28/15 with CNA #10 at 2:04 PM, Unit Manager of Homestead at 2:15 PM, LPN #13 at 1:30 PM, CNA #19 at 3:16 PM, and CNA #20 at 3:24 PM. The staff stated they had received training on the Elopement Policy and what to do when a door alarm sounded. The staff had good knowledge of the process and stated they had to take a post-test and score 95%.</p> <p>On 12/29/15, the following staff were interviewed regarding the training they received: CNA #7 at 9:07 AM, CNA #11 at 9:12 AM, CNA #12 at 9:14 AM, CNA #13 at 9:30 AM, CNA #4 at 9:41 AM, CNA #14 at 3:19 PM, CNA #15 at 3:04 PM, CNA #16 at 9:25 AM, CNA #17 at 3:07 PM, CNA #18 at 3:23 PM, CNA #19 at 3:16 PM, and CNA #20 at 3:24 PM. The staff was knowledgeable of the facility's Elopement Policy and what to do if the door alarm was activated. They were required to take a post-test and score 95%.</p> <p>Interviews conducted on 12/29/15 with Licensed Practical Nurse (LPN) #1 at 9:02 AM, LPN #14 at 9:05 AM, LPN #9 at 9:28 AM, LPN #15 at 9:25 AM, #9 at 9:42 AM, LPN #17 at 2:28 PM, and LPN #16 at 2:35 PM revealed they had received re-education on the Elopement Policy, they are responsible for checking the Wander Guard devices three (3) times a day and record the checks on the Treatment Administration Record (TAR). In addition, care planning was reviewed.</p> <p>Interview with the Unit Manager of Homestead,</p>	F 323	INTENTIONALLY LEFT BLANK	

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F 323	<p>Continued From page 68</p> <p>on 12/28/15 at 2:15 PM, and NF1 Unit, on 12/29/15 at 10:30 AM, revealed training was provided to them and a post-test was required. The Managers are responsible for audits of the TAR and to ensure the nurses are checking the Wander Guard devices.</p> <p>Interview with Housekeeper #1, on 12/29/15 at 9:17 AM, and Housekeeper #2 on 12/29/15 at 9:00 AM, revealed the facility provided training for all contract housekeeping staff regarding the facility's Elopement Policy and what to do when a door alarm sounded.</p> <p>Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, and the Maintenance Assistant, on 12/29/15 at 8:34 AM, revealed they received training on the Elopement Policy and door alarms. They took the post-test also.</p> <p>Interview with the Staff Educator, on 12/29/15 at 4:26 PM, revealed she had provided most of the training. She stated she conducted most training in small groups. She stated she developed talking points for the elopement and care plan education. These talking points were the bases for the post-test that each employee was required to take. She stated the education included door codes not to be given out to anyone that was not an employee of the facility and door alarms and how to respond.</p> <p>11. Observation on 12/28/15 at 1:05 PM, revealed posting of the written education on all four units.</p> <p>12. Observations during the extended survey revealed facility assisting visitors when exiting the building including surveyors on 12/28/15 through 12/30/15. Observation upon entrance to the</p>	F 323	INTENTIONALLY LEFT BLANK	

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F 323	<p>Continued From page 69</p> <p>facility on 12/28/15 at 11:05 AM revealed the sign was posted at the Entrance A doors and observation at 11:20 AM revealed the sign was posted on the Entrance B doors and the Homestead Unit doors.</p> <p>Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, revealed a new timer was placed on the Entrance B keypad to lock the doors from 7:00 PM to 8:00 AM. He stated a visitor will have to ring a bell and staff will have to go to the door to let the person in. When the visitor is ready to leave the building, staff would assist by opening the door, using the coded keypad.</p> <p>13. Review of the letters, dated 12/21/15, revealed letters were sent to the vendors, families, and physician notifying them of the new security measures.</p> <p>14. Review of the audits revealed the elopement drills were conducted as stated. Audits will be reviewed during the morning meeting to ensure the audits were completed.</p> <p>Interview with the Director of Nursing, on 12/30/15 at 8:59 AM, revealed elopement drills were conducted and the audits were discussed during the morning meetings.</p> <p>15. Observation of a Wander Guard device check, on 12/28/15 at 1:27 PM, in the Homestead Secure Unit, revealed all residents' Wander Guard devices were applied and functioning properly.</p> <p>Review of the TAR revealed the facility had increased the Wander Guard device checks to</p>	F 323	<p><b>INTENTIONALLY LEFT BLANK</b></p>	

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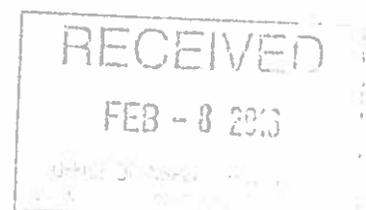
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F 323	<p>Continued From page 70</p> <p>three (3) times a day, where the checks were previously twice a day. Review of all residents with a Wander Guard device revealed the checks were being done.</p> <p>Interview with the Unit Manager of Homestead, on 12/28/15 at 2:15 PM, and NF1 Unit, on 12/29/15 at 10:30 AM, revealed the Unit Managers are responsible for audits of the TAR to ensure the nurses are checking the Wander Guard devices.</p> <p>16. Interview with the Maintenance Director, on 12/29/15 at 2:23 PM, revealed all exit doors were checked daily. Observation on 12/29/15 at 8:34 revealed the Maintenance Assistant tested all exit doors in the Homestead Unit. All doors were functioning properly.</p> <p>Review of documentation revealed the new key pad was installed on 12/29/15. The Entrance B locking system was audited daily. Review of the door audits revealed no problems found.</p> <p>17. Review of the Quality Improvement Meeting on 12/21/15 revealed all members present including the Medical Director.</p> <p>Interview with the Administrator, on 12/30/15 at 8:02 AM, revealed the Ad-Hoc meetings are additional meetings between the official Quality Assurance meetings scheduled monthly. The Quality Improvement meeting held on 12/21/15, with the Medical Director in attendance, was to review the AOC and review any audits to that date. The next scheduled Quality Improvement meeting is scheduled for 01/17/16. The Administrator stated audits would be reviewed at each meeting until compliance is achieved.</p>	F 323	<p>INTENTIONALLY LEFT BLANK</p>	

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F 323	Continued From page 71	F 323			
F 332 SS=D	<p>Interview with the Medical Director, on 12/30/16 at 9:42 AM, revealed he was present at the Quality Improvement meeting held on 12/21/15. He stated he was involved in the development of the AOC as the facility asked for his input. The facility discussed the corrective actions and the committee approved the audit tools. He stated the facility had notified him of the Immediate Jeopardy and informed him of the details and the action plans that had been implemented. He stated he was committed to attending the next Quality Improvement meeting scheduled for 01/07/16.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure they were free of medication errors of 5% or greater. Medication pass presented thirty-five (35) opportunities with a total of two (2) errors resulting in a 5.71% medication error rate. LPN #8 failed to administer two (2) medications ordered for the morning medication pass for Unsampled Resident M.</p> <p>The findings include: Review of the facility's Medication Error Policy, revised 01/02/14, revealed a medication error</p>	F 332	<p>F 332</p> <ol style="list-style-type: none"> <li>1. Unsampled resident M's physician was notified on December 16, 2015 by Unit Manager. On December 16, 2105 the Unit Manager assessed Resident M and determined the resident did not experience any negative outcome. The Medication Administration Record was updated by the Unit Manager to reflect current medication orders on December 16, 2015. LPN #8 received reeducation regarding the need to administer all medications as ordered by Unit Manager on December 16, 2015.</li> <li>2. All residents of the facility have the potential to be affected. A physicians' order audit compared to the medication administration records and medication cart audit was conducted by the Unit Managers on December 16, 2015 to determine 1) medications were available to administer to the residents of the facility and 2) that medication administration records are in place per physician's orders. Areas of concern were corrected upon discovery.</li> </ol>	2/13/16	



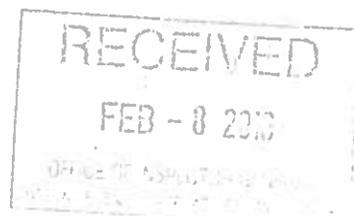
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F 332	<p>Continued From page 72</p> <p>was defined as a discrepancy between what the physician/mid-level provider ordered and what the resident received. Types of medication errors included medication omissions.</p> <p>Observation of Unsampled M's medication pass, on 12/16/15 at 9:40 AM, revealed Licensed Practical Nurse (LPN) #8 did not administer Buspar 30 mg or Gabapentin 600 mg during her morning medication pass.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 12/16/15 at 9:20 AM, revealed she was not aware she was to administer Buspar and Gabapentin medication to Unsampled Resident M because it was not on the Medication Administration Record (MAR) to give. If a medication was not given then the omission was an error.</p> <p>Review of Unsampled Resident M's Physician Orders, dated 12/11/15 at 11:30 AM, revealed the physician ordered Buspar 30 mg twice a day, Gabapentin 300 mg at 2:00 PM, and Gabapentin 300 mg, two (2) in the morning and two (2) at night.</p> <p>Interview with the Nurse Practice Educator, on 12/17/15 at 9:50 AM, revealed she had not conducted any medication pass with staff since hired seven (7) months ago. The only discrepancies she had found was when the nurses circled that they did not administer a medication, the nurses were not documenting as to why the medication was not given. The Nurse Practice Educator stated a medication error rate of five (5) percent was too high.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 332	<p>3. The Nurse Practice Educator and or a Pharmacy Representative conducted re-education regarding need to ensure that the facility is free of medication error rates of five percent or greater for Licensed Nurses including medication administration and process for processing and ordering medications on December 19, 2015, including completion of the Medication Administration Record. A medication administration competency and post-test was completed after the re-education with a passing score of 95% graded by the Director of Nurses or Nurse Practice Educator to determine understanding of the information presented. Staff not available during this timeframe including new hires with orientation will complete reeducation with a posttest by the Director of Nurses or Nurse Practice Educator to validate understanding upon return to work.</p>	2/13/16



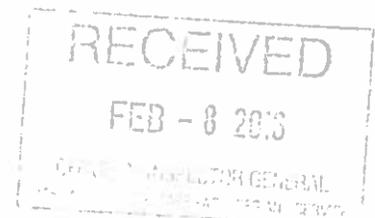
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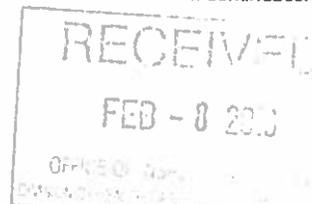
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F 332	Continued From page 73 12/17/15 at 1:24 PM, revealed she had not been able to review a medication administration pass with staff since hired. The DON stated she would like to have a medication error rate of zero (0) percent and five (5) percent was too high. The DON stated the pharmacy had come in to complete a medication pass, but only found that some of the medications were not dated when opened or the orders was missing a diagnosis. The DON stated if Unsampled Resident M did not receive his/her medication, he/she would not be able to combat the symptoms they were having medically.	F 332	Visual medication pass observation audits will be conducted over all 3 shifts daily times 2 weeks then 3 times per week times 2 weeks then weekly times 8 weeks then monthly times 3 months by the Director of Nursing and or Unit Managers to ensure medications are administered as ordered. A Visual comparison of the physicians' orders and the medication administration record will be conducted for 5 residents 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months.	
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to record food temperatures, and failed to ensure temperatures were taken for one (1) of three (3) units in the Homestead Unit.  The findings include:  Review of the facility's policy regarding Thermometer Use, dated 12/01/15, revealed the facility's kitchen staff would test the food throughout the preparation and service to ensure	F 364	Concerns will be corrected upon discovery.  4. The Director of Nursing and or the Unit Managers will submit a summary of the audit findings monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or in-servicing needs until the Issues is resolved and ongoing thereafter.	2/13/16



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F 364	<p>Continued From page 74</p> <p>the appropriate temperature of the food was reached and maintained. The facility would take the temperature of the food and record the holding temperature of foods held for service on the Production Sheet.</p> <p>Review of the facility's policy regarding Food Handling, dated 12/01/15, revealed the kitchen employees would take and record the food temperatures on the tray line and record those temperatures on the production Worksheets at the beginning of each meal service. The policy additionally stated if the facility utilized a remote meal assembly, staff would take the holding temperatures of food and record those temperatures at each of those locations.</p> <p>Observation of the dining experience on the Homestead Unit, on 12/15/15 at 11:30 PM, revealed food was delivered in a cart. The nurse, who had on a hair resiraint, removed the food (which was in silver cooking pans) from the cart and separated the regular food from the pureed food while placing the food on the kitchen counter. The nurse then removed the foil from the pans and began to plate food based on the meal ticket she had before her. There was no steam table present and no temperatures taken of the food before it was plated by the staff. There were twenty-four (24) residents in the dining room all sitting at multiple tables. The food was served from the kitchenette area and staff passed out the plates.</p> <p>Observation of the dining experience on the Homestead Unit, on 12/16/15 at 11:20 AM, revealed the food arrived to the unit. Meals were served starting at 11:42 AM; no temperatures were obtained of the food that was provided.</p>	F 364	<p>F364</p> <ol style="list-style-type: none"> <li>On December 17, 2015, for dinner meal on Homestead, an initial audit was conducted by Director of Dining Service to ensure temperatures of all food items were obtained and properly documented on the production sheets with no concerns.</li> </ol> <p>All residents of the facility have the potential to be affected. The Executive Chef or Director of Dining Services observed dining room on all units including Homestead to ensure that food temperatures were obtained and recorded on January 11, 2016 with corrective action upon discovery.</p> <ol style="list-style-type: none"> <li>The Director of Dining Services and or the Executive Chef will reeducate all dietary staff on or before February 5, 2016 regarding need to ensure each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature including temperatures of food were properly documented with a posttest completed to validate understanding with a passing</li> </ol>	2/13/16	



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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
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F 364	<p>Continued From page 75</p> <p>Observation of the food temperatures taken after all the residents were served, on 12/16/15 at 12:06 PM, revealed the Stuffed Peppers were 110 degrees Fahrenheit (F), Rice was 104 degrees (F), Potato Soup was 102 degrees (F) and the Purée Stuffed Peppers were 99 degrees (F).</p> <p>Interview with Lead Cook #1, on 12/16/15 at 1:45 PM, revealed kitchen staff should have taken food temperatures when the food came out of the oven, in the middle of the food service, and at the end of the food service. He stated employees should have written down the temperatures after taking them. He stated he usually wrote down all of the food temperatures after taking temperatures of the food. However, he could not produce a log where he documented food temperatures.</p> <p>Interview with the Executive Chef, on 12/16/15 at 11:46 AM, revealed since he had worked at the facility for the last two (2) months, he noticed there was no steam table on the Homestead Unit. The Executive Chef stated the meal service was not family style dining. He stated family style dining meant the food would be served at the table and not from a kitchenette. The Executive Chef stated he thought there was a proposal for a steam table.</p> <p>Further interview with the Executive Chef, on 12/16/15 at 11:52 AM, revealed the food was temped before delivery to the Homestead Unit. He stated the holding temperature for the food before delivery to the Homestead Unit would be 180 degrees (F). The Executive Chef stated if the Potato soup temperature was not appropriate it could make the residents sick because of the</p>	F 364	<p>score of 95% graded by the Director of Dining Services and/or Executive Chef. Staff not available during this timeframe including new hires with orientation will complete reeducation with a posttest by the Director of Dining Services or Executive Chef to validate understanding upon return to work.</p> <p>3. The Director of Dining Services and/or the Executive Chef and or the Manager on Duty and or Assistant Administrator will complete audits to ensure that temperatures of all food items are obtained and properly documented on the production sheets across 3 meals per day for 2 weeks, including weekends, then 3 times a week for 2 weeks, weekly for 8 weeks and monthly for 3 months then as recommended by the Quality Improvement Committee.</p> <p>4. The Director of Dining Services and or Executive Chef will submit a summary of the audit findings for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining</p>	9/13/16

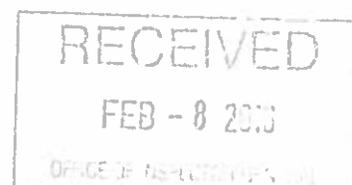
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F 364	<p>Continued From page 76</p> <p>milk that was used to make the soup.</p> <p>Additional interview with the Executive Chef, on 12/16/15 at 1:50 PM, revealed the Homestead Unit did not do family style dining. He stated instead of family style dining, the kitchen staff took the food to the Homestead Unit and the nursing staff would plate the food. Prior to taking the food to the Homestead Unit, kitchen employees take the temperature of the foods. He stated he never recorded food temperatures of food going to the Homestead Unit or of food on the tray line.</p> <p>Interview with the Dietary Manager, on 12/17/15 at 11:26 AM, revealed her main priority was to get meals out to the units on time. The Dietary Manager stated the temperatures of the meals had not been documented, there was no log to review to ensure the temperatures were taken before transport to the Homestead unit.</p> <p>Interview with the Administrator, on 12/17/15 at 1:45 PM, revealed he had not monitored the temperature logs and was not aware the staff was not recording the temperatures from the tray line. The Administrator stated Family Style Dining was food being prepared in the kitchen and then served on dishes. The food would be offered at the table. The Administrator stated he recognized the problem last month; however, there was no plan of action.</p>	F 364	<p>Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p> <p>F371</p> <p>1. On December 17, 2015 the Director of Dining Services and/or Executive Chef completed observation of the dietary department to ensure that 1) the floor and equipment were clean; food items were covered, labeled and dated; and refrigerators contained thermometers both in the kitchen and on the units, 2) Dietary staff changed gloves with appropriate handwashing between tasks and staff contained hair and beards in protectors, 3) there were no scoops left in containers or in the ice chest, 4) the garbage can had a lid, and 5) there were Quat chemical test strips available for the three compartment sink and the dishes and carts were completely air dry prior to meal service with corrective action upon discovery.</p>	2/13/16
F 371 SS=F	<p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local</p>	F 371		



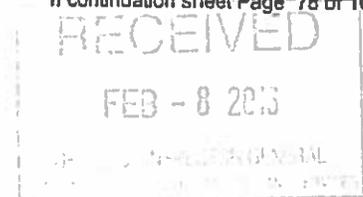
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F 371	<p>Continued From page 77 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to store and serve food in a sanitary manner. The kitchen had a build-up of food particles on the floor and equipment; food items were not covered, labeled or dated; and, two (2) of (4) refrigerators did not have thermometers. Dietary staff did not change gloves between tasks; staff did not contain hair and beards in protectors; there were scoops left in containers; and, a garbage can had no lid. In addition, there were no chemical test strips available for the three compartment sink.</p> <p>The findings include:  Review of the facility's policy regarding Department Sanitation, dated 10/01/15, revealed the facility would maintain the Food and Nutrition Service Department in a clean and sanitary manner to ensure food and beverages were stored, prepared, and served in a clean and sanitary environment.  Review of the facility's policy regarding Cleaning Standards, dated 12/01/15, revealed the food and nutrition service employees were to ensure all</p>	F 371	<p>2. All residents of the facility who consume meals prepared from the kitchen have the potential to be affected. On December 17, 2015, the Director of Dining Services and or Executive Chef completed observation of the dietary department to ensure that 1) the floor and equipment were clean; food items were covered, labeled or dated, and refrigerators contained thermometers both in the kitchen and on the units, 2) Dietary staff changed gloves with appropriate handwashing between tasks and staff contained hair and beards in protectors, 3) there were no scoops left in containers or in the ice chest, 4) the garbage can had a lid, and 5) there were Quat chemical test strips available for the three compartment sink and the dishes and carts were completely air dry prior to meal service with corrective action upon discovery.</p>	2/13/16



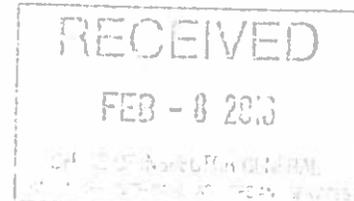
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F 371	<p>Continued From page 78</p> <p>food service equipment and areas were cleaned and sanitary. Cleaning and sanitizing agents would be available for use during all hours of operation. All areas included baseboards, floors, storage cabinets and shelves, toaster, and walls.</p> <p>Review of the facility's policy regarding Cleaning Schedules, dated 12/01/15, revealed the Food and Nutrition Service Department were to use an established cleaning schedule which identified routine cleaning for all department equipment and areas. The Director of Dining Services would post the weekly department Cleaning Schedule in an area accessible to the Food and Nutrition Service employees. Employees would clean the assigned equipment or areas as scheduled following the cleaning procedures.</p> <p>Review of the facility's Master Cleaning Schedule revealed the frequency at which the food and nutrition service employees would clean areas of the kitchen. Facility employees would clean baseboards quarterly; the floors monthly; the storage cabinets and shelves weekly; and, the walls weekly. The garbage can was on the cleaning list; however, the list did not indicate the frequency at which employees were to clean it. The list did not indicate what frequency employees were to clean the knife rack.</p> <p>Review of the facility's policy regarding Food Handling, dated 12/01/15, revealed the facility foods would be stored, prepared, and served in a safe and sanitary manner to prevent bacterial contamination and the possible spread of infection. Staff would cover and place a label on any opened or unused portions. The label would include a "use by" date. The policy further stated employees would store ice scoops in a covered</p>	F 371	<p>On January 28, 2016 The Director of Dining Services and/or Executive Chef provided reeducation to all dietary employees to ensure that the facility would maintain the Food and Nutrition Service Department in a clean and sanitary manner to ensure food and beverages were stored, prepared, and served in a clean and sanitary environment with a posttest completed to validate understanding with a passing score of 95% graded by the Director of Dining Services and/or Executive Chef. Staff not available during this timeframe including new hires with orientation will complete reeducation with a posttest provided by the Director of Dining Services or Executive Chef to validate understanding upon return to work.</p> <p>3. The Director of Dining Services and or Executive Chef and or Manager on Duty and or Assistant Administrator will complete audits at each meal service (3 times per day) times 2 weeks to include weekends, then daily times 2 weeks, then 3 times per week for 2 weeks, then weekly for 8 weeks and monthly for 3 months and then as determined by the Quality Improvement Committee to ensure that 1) the floor and equipment are clean; food</p>	2/13/16



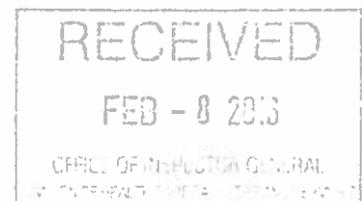
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F 371	<p>Continued From page 79</p> <p>container with drainage outside the ice machine. Additionally, the policy stated kitchen employees would wash their hands frequently and wear disposable gloves when handling food. Employees would change gloves after each task.</p> <p>Review of the facility's policy regarding Refrigeration and Freezer Temperature Standards, dated 12/01/15, revealed the facility would ensure foods held in refrigerated equipment would be maintained at a safe temperature. The Director of Dining Services would observe and record all of the temperatures of refrigerators and freezers on a daily basis using the Refrigerator/Freezer Temperature Log. Internal thermometers would be located near the door of each refrigerator and freezer.</p> <p>Review of the facility's policy regarding Dining Service Standards, dated 03/16/15, revealed the facility would train all staff involved with meal service on safe food handling practices. Staff would utilize proper hand washing and glove use when serving food to residents.</p> <p>Review of the facility's policy regarding Hand Washing, dated 03/16/15, revealed kitchen staff would wash their hands after touching their hair, ears, nose, or mouth, after handling any food, after contacting any soiled utensils, before touching any clean utensils plates, cups, or pans, or when moving from one task to another. The policy stated use of disposable gloves did not replace proper hand washing.</p> <p>Review of the facility's policy regarding Personal Hygiene, dated 12/01/15, revealed the kitchen employees would use hair restraints such as hats, hair coverings, or nets to keep hair from</p>	F 371	<p>items are covered, labeled or dated; and refrigerators contain thermometers both in the kitchen and on the units, 2) Dietary staff change gloves with appropriate handwashing between tasks and staff have hair and beards in protectors, 3) there are no scoops left in containers or in the ice chest, 4) the garbage can has a lid, and 5) there were Quat chemical test strips available for the three compartment sink and the dishes and carts were completely air dry prior to meal service with corrective action upon discovery.</p> <p>4. The Director of Dining Services and c. Executive Chef will submit a summary of the audit findings for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p>	2/13/16



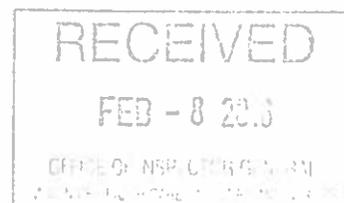
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F 371	<p>Continued From page 80</p> <p>contacting exposed food. Staff would use facial hair coverings to cover all facial hair. Employees would use disposable gloves and change them between tasks.</p> <p>Review of the facility's policy regarding Department Sanitation, dated 10/01/15, revealed the facility would ensure trash was in covered containers. Kitchen staff would ensure the sanitation bucket solutions were at the appropriate concentration. Kitchen staff would also keep the floors clean and free of debris. Staff would follow cleaning schedules and utilize the cleaning procedures. Staff would ensure the pots and pan sink was properly filled with hot water, detergent, and sanitizing solution at the appropriate concentration.</p> <p>Review of the facility's policy regarding Manual Ware washing and Sanitizing, dated 12/01/15, revealed the kitchen staff would test the solution strength in the chemical sanitization sink during each wash period using Quaternary test strips. Staff would accomplish manual ware washing using a three-compartment sink for washing, rinsing, and sanitizing. During chemical sanitizing, the Director of Dining Service or designee would test the solution strength during each wash period using Quaternary test strips. The designee would measure the Quaternary product by dipping the test strip into the solution for ten (10) second then checking the strip against the strip container. The test strip should darken to the range of 150-400 ppm for proper solution strength. If the test strip did not turn the appropriate darkness, staff would make corrections before the sanitizing process could take place. Staff would record the results of the test on the Manual Ware washing Sanitation Log</p>	F 371	INTENTIONALLY LEFT BLANK	



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F 371	<p>Continued From page 81 at each wash period.</p> <p>1. Observations of the kitchen during the initial tour, on 12/15/15 at 8:10 AM, revealed a buildup of food particles on the floor in the pantry and kitchen. The floor in the pantry had a spill of a white powdery substance on the floor. In the kitchen, the knife holder on the wall had a buildup of a greasy like substance and crumbs on the top. The knife holder was a metal box with a black plastic lid with slits in it. Several knives were in the knife holder at the time of the observation.</p> <p>Interview with the Executive Chef, on 12/16/15 at 1:50 PM, revealed he and the Dietary Manager were responsible for the sanitation of the kitchen. He stated the kitchen staff was not maintaining the kitchen per the cleaning schedule. The Chef stated the kitchen staff utilized a cleaning schedule, but the staff was running approximately forty-eight (48) hours behind on the cleaning schedule. The cleaning schedule included cleaning under shelves, dry storage, walls, and coolers and the staff should have been cleaning those areas. The Chef also stated he was unaware of the buildup on the knife holder in the kitchen.</p> <p>Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed she had previously identified concerns with sanitation and documentation in the kitchen. The Dietary Manager stated she was working on incorporating a new cleaning schedule to improve sanitation. She stated the kitchen had recently hired several new employees and training was ongoing in the kitchen. The Dietary Manager stated she was unaware of the build-up on the knife holder.</p>	F 371	<p><b>INTENTIONALLY LEFT BLANK</b></p>	
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F 371	<p>Continued From page 82</p> <p>Observation of the kitchen during the initial tour, on 12/15/15 at 8:10 AM, of the walk in refrigerator in the kitchen revealed no thermometer in the refrigerator. The refrigerator contained two (2) large shallow pans containing beans and water. The two pans were uncovered and had no date or label on the pans and were sitting on the lowest shelf. The refreshment refrigerator in the kitchen contained five (5) containers of unlabeled, undated substances. Three (3) of the containers appeared to hold liquids. One (1) container appeared approximately half-full of a purple jelly like substance. One (1) container contained a green solid substance. Other observations during tour included a large garbage can in the kitchen with no lid.</p> <p>Interview with Lead Cook #1, on 12/16/15 at 1:45 PM, revealed it was the responsibility of all of the kitchen employees to label any food items stored in the refrigerators or freezers.</p> <p>Interview with Lead Cook #2, on 12/15/15 at 8:10 AM, revealed the walk in refrigerator should have a thermometer in it to ensure the temperature of the refrigerator. He stated he noticed two thermometers in the walk in freezer and thought an employee may have relocated the thermometer from the refrigerator into the freezer. In addition, the shallow pans on the bottom shelf of the walk in refrigerator contained beans soaking in water. He stated staff should have covered and labeled the beans and should not have placed them on the lowest shelf in the refrigerator. The cook further identified the contents of the five (5) containers in the refreshment refrigerator. He stated the kitchen employee who put the containers in the</p>	F 371	INTENTIONALLY LEFT BLANK	

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F 371	<p>Continued From page 83</p> <p>refrigerators should have placed labels on the containers. The three (3) containers of liquid held orange juice, cranberry juice, and apple juice. The other two (2) containers held green Jell-O and jelly.</p> <p>Continued interview, on 12/16/15 at 1:50 PM, with the Chef revealed staff should have labeled all food prior to placing it in the refrigerator. If items were found in the refrigerator unlabeled and undated, those items should have been disposed of. He further stated that staff should not have left the two (2) pans of beans on the lowest shelf to soak and staff should have covered the pans.</p> <p>Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed the facility had improved on the labeling of stored foods; however, the kitchen continued to work to improve in this area. She stated staff should not have stored pans of beans uncovered and unlabeled in the refrigerator while they soaked. She stated that without a label there was no way to know how long items had been in the refrigerator or what the item was. This could have potentially led to food borne illness.</p> <p>Observation of the kitchen prior to and during the lunch meal service, on 12/16/15 at 11:00 AM, revealed kitchen employees did not perform hand hygiene or change gloves between tasks. Lead Cook #1 left the workstation and went to other areas of the kitchen, touching items in the kitchen, and returned to the workstation without washing his hands or changing his gloves. He also left the kitchen, touched the door when he entered the dining room, and used the doorknob to return to the workstation. The cook did not wash his hands or change his gloves prior to handling food again.</p>	F 371	INTENTIONALLY LEFT BLANK	

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F 371	<p>Continued From page 84</p> <p>Interview with Lead Cook #1, on 12/16/15 at 1:45 PM, revealed staff should change gloves and wash hands any time they leave the serving station in order to keep the food sanitary. He stated he thought he did wash his hands each time after leaving the food serving station.</p> <p>Additional interview with the Chef, on 12/16/15 at 1:50 PM, revealed the Chef stated kitchen employees should have worn gloves whenever handling food. Employees should have changed gloves between tasks or whenever touching anything else. He stated the cook should have washed his hands and changed gloves after touching the door to and from the dining room.</p> <p>Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed employees should have washed their hands and changed their gloves every time they changed tasks.</p> <p>Observation of the kitchen prior to and during the lunch meal service, on 12/16/15 at 11:00 AM, further revealed kitchen employees not properly using hair restraints. A Dietary Aide wore a hair net, but had her bangs outside of the hair restraint. Lead Cook #1 and the Chef had beards and did not contain their beards in any type of net.</p> <p>Interview with Lead Cook #1, on 12/16/15 at 1:45 PM, revealed staff did not cover their beards and bangs in the kitchen.</p> <p>Further interview with the Chef, on 12/16/15 at 1:50 PM, revealed he had spoken with the kitchen aid the previous day about her hair being out of the hair restraint. He stated he noticed she</p>	F 371	<p>INTENTIONALLY LEFT BLANK</p>	

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F 371	<p>Continued From page 85</p> <p>still had some bangs out of the hair net at the time of the meal observation, but did not mention it to her at that time. The Chef also stated he did not realize staff needed to restrain short beards in a hair restraint.</p> <p>Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed she noticed one of the kitchen aides with her bangs out of the hair net, but did not talk to her about her hair at that time. She also stated she was unaware beards must also be kept in a hair restraint.</p> <p>Observation of the kitchen prior to and during the lunch meal service, on 12/16/15 at 11:00 AM, also revealed a scoop left in a container of thickener throughout the meal service.</p> <p>Observation revealed a large garbage can in the kitchen with no lid. Employees used this garbage can and placed food waste, wet paper towels, soiled gloves, and packaging in this garbage can throughout the meal service.</p> <p>Interview with the Chef, on 12/16/15 at 1:50 PM, revealed the garbage can in the kitchen should have had a lid, as it is unsanitary; however, the kitchen had no lid for the garbage can. He stated he was not able to acquire new items for the kitchen, such as garbage can lids, until the new fiscal year due to budgetary constraints.</p> <p>Observation of the kitchen prior to and during the lunch meal service, on 12/16/15 at 11:00 AM, further revealed the knife holder on the wall near the food preparation area continued to have a thick greasy substance and crumbs on the top of it. During the meal preparation and service, the chef removed a knife from the holder and used it to cut food items. Additionally, the floors in the</p>	F 371	INTENTIONALLY LEFT BLANK	

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F 371	<p>Continued From page 86</p> <p>kitchen contained crumbs, food, and paper items near and under the food preparation tables. The floor in the dry storage area had white powder, red powder, crumbs, beans, and dust build up under and behind the shelves.</p> <p>Observation of the refrigerator on the Rehab Unit, on 12/16/15 at 1:30 PM, revealed the refrigerator did not contain a thermometer. The refrigerator contained a gallon container of milk and a gallon container of chocolate milk.</p> <p>Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed she had not been monitoring the kitchenette area in the Rehab Unit because the kitchen did not serve food from the steam tables in that dining room. She stated she had not inspected the refrigerator on that unit and could not speak to the refrigerator not having a thermometer. She stated that she was unsure if the refrigerator fell under the jurisdiction of nursing or of the kitchen, but that it likely should have been monitored by the kitchen staff.</p> <p>Observation of the ice chest in the dining area, on 12/16/15 at 1:45 PM, revealed the ice scoop resting in the ice chest with the ice. There was no ice scoop holder on or around the location of the ice chest.</p> <p>Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed staff should not have left scoops in the thickener or in the ice chests. This could lead to bacterial cross contamination and food borne illnesses. The Dietary Manager stated she recognized the garbage can did not have a lid on it.</p> <p>Observation of the kitchen sanitation, on 12/16/15</p>	F 371	INTENTIONALLY LEFT BLANK	

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F 371	<p>Continued From page 87</p> <p>at 1:50 PM, revealed staff did not test the sanitation sink for the correct chemical sanitation level prior to washing pots and pans in the kitchen. Kitchen staff was washing pots and pans in the three (3) compartment sink at the time of the observation. During the course of the sanitation tour, the Chef used a chemical strip to test the chemical level in the sanitation sink. The strip read the chemical sink measured at 10 parts per million (ppm). The strip container stated the correct chemical concentration should read between 150-400 ppm.</p> <p>Interview with the Chef further revealed the kitchen staff did not test and record the chemical sink for correct sanitation level. He stated the last recorded testing of the sanitation sink was in October 2015. The Chef used a test strip to test the chemical level and stated the test strip read 10 ppm when it should have read 150-400 ppm.</p> <p>After closer look at the test strips, the Chef stated the chemical strips tested for chlorine and the kitchen used four-quat cleaner. He stated the facility did not have test strips to test four-quat cleaner in the chemical sanitation sink and that the kitchen staff could not have tested for correct chemical sanitation level in the sink.</p> <p>Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed the kitchen used the wrong strips to test for the correct chemical level in the sanitation sink. She stated the staff had been using strips that test for chlorine and the facility used four-quat. She stated that staff had been using the test strips, but not documenting the results and not reporting that the test strips were not changing color. The facility did not have four-quat test strips.</p>	F 371	INTENTIONALLY LEFT BLANK	

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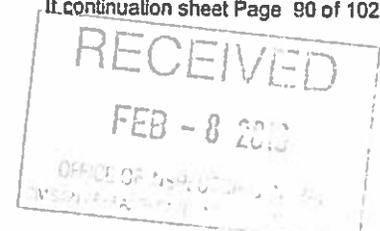
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F 371	Continued From page 88  2. Observation of the Homestead dining experience, on 12/16/15 at 11:50 AM, revealed the Unit Manager serving food on wet dishes. There were eight (8) wet plates and seven (7) wet bowls utilized by the Unit Manager.  Interview with the Executive Chef, on 12/16/15 at 11:52 AM, revealed dishes should be dry; if the dishes were wet it could be a breeding ground for bacteria.  Observation of a tray delivery to the Transitional Care Unit (TCU) dining area, on 12/16/15 at 1:12 PM, revealed two (2) meal trays were delivered to the TCU dining area by the Scheduling Manager on a wet cart.  Interview with the Scheduling Manager, on 12/16/15 at 1:12 PM, revealed she saw the dietary staff spray the cart off, but the staff did not dry the cart before she delivered the trays.  Interview with the Dietary Manager, on 12/16/15 at 4:45 PM, revealed the plates may have been wet if the kitchen staff did not let them sit long enough to dry prior to stacking them. She stated stacking wet plates created a breeding ground for bacteria. The Dietary Manager stated these sanitation concerns put residents at risk of cross contamination and food borne illnesses  Interview with the Administrator, on 12/17/15 at 1:12 PM, revealed the facility had previously identified sanitation as an area of concern. He also stated he was aware of the issues in the kitchen because of the survey results from the previous year. The Administrator stated he was concerned that some of the identified issues	F 371	INTENTIONALLY LEFT BLANK		

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F 371	Continued From page 89 remained. The Administrator stated he had reviewed the food service auditing tool; however, he had not been monitoring the actual food service audits to ensure sanitation. He stated he had not asked the Dietary Manager for a copy of the audits to review.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F 431  1. The expired medication for unsampled residents H and I was removed from the NF1 medication cart by the Unit Manager on 12/16/2015. The EDK box in the NF1 medication room was secured with a numerated plastic seal by the Unit Manager on 12/16/2015.  2. All residents of the facility have the potential to be affected. The Unit Managers and or pharmacy representative completed audits of all medication carts on December 30, 2015 to ensure that expired and or discontinued medications had been removed from the cart. Concerns identified were corrected upon discovery.  The Unit Manager covering NF1, NF2, TCU and the Homestead Unit checked all EDK boxes on December 16, 2015 to determine if they were locked and secured with a numerated plastic seal. Areas of concern were corrected upon discovery.	2/13/16



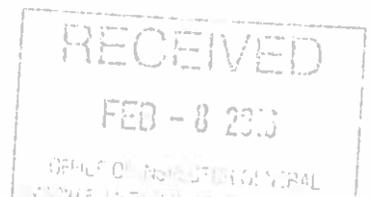
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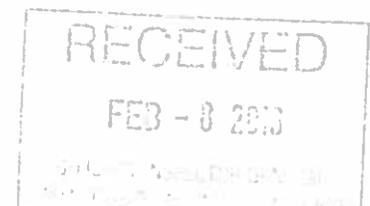
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F 431	<p>Continued From page 90 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures, it was determined the facility failed to ensure drugs and biologicals used in the facility were not expired or discontinued for two (2) of fourteen (14) unsampled residents, Unsampled Resident H and Unsampled Resident I, and failed to assure one (1) of one (1) Emergency Drug Kit (EDK) was sealed.</p> <p>The findings include: Review of the facility's policy, regarding Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles, dated 08/01/02 and revised 05/16/11, revealed drugs, biologicals, syringes, and needles would be stored under proper conditions with regard to sanitation, temperature, light, moisture, ventilation, segregation, safety, security, and expiration date as directed by state and federal regulations and manufacturer/supplier guidelines.</p> <p>1. Observation of the medication cart on Nursing Facility 1 (NF1), on 12/16/15 at 11:10 AM, revealed expired and discontinued medications; a narcotic and an antianxiety medication. Unsampled Resident H's Tramadol 50 mg per tablet had expired on 01/26/15. Unsampled Resident I's Lorazepam 0.25 mg had been</p>	F 431	<p>3. The Nurse Practice Educator and or Pharmacy Representative conducted re-education to ensure drugs and biologicals used in the facility were not expired or discontinued and that Emergency Drug Kit (EDK) is secured with a numerated plastic seal for License Nurses on January 19, 2016. The re-education covered medication ordering and storing of medications to include locking the EDK box. A post-test was completed after the re-education with a passing score of 95% graded by the Director of Nurses or Nurse Practice Educator to validate understanding of the information presented. Staff not available during this timeframe including new hires with orientation will complete re-education with post-test provided by the Director of Nurses or Nurse Practice Educator to validate understanding upon return to work.</p>	2/13/16



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F 431	<p>Continued From page 91</p> <p>discontinued since 09/17/15. Both medications were on the NF1 medication cart at the time of inspection and were available for use.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/16/15 at 11:23 AM, revealed she understood the process of disposal of discontinued and expired narcotics and antianxiety medications, but kept the expired and discontinued medications in the cart. LPN #3 stated she was supposed to inform the Unit Manager, and/or the Director of Nursing (DON), the medications would be signed out of the narcotic book and removed from the cart. The DON and another nurse were to destroy the expired and discontinued medications with a witness.</p> <p>Interview with the DON, on 12/16/15 at 3:50 PM, revealed she would pull expired and discontinued medications, including narcotics and antianxiety medications, from the cart at least monthly. She would have expected nurses to inform her about expired and discontinued medications. The DON stated all medications should have been dated when opened to monitor for expired dates or discontinued narcotics and antianxiety medications. These medications should have been brought to her attention by the nurse.</p> <p>2. Observation and inspection of the medication room, on 12/16/15 at 9:23 AM, revealed the Emergency Drug Kit (EDK) on NF1 was not sealed with a numerated plastic seal. Continued inspection of the process revealed the pharmacy Emergency Box Usage Sheet (EBUS) was only partially completed and no seal number was captured on the pharmacy EBUS.</p>	F 431	<p>The Director of Nursing and or Unit Managers will complete audits of the medication carts and medication rooms to determine expired/discontinued medication are remove and EDK boxes are locked and secured with a numerated plastic seal daily times 2 weeks including weekends, 2 times a week times 8 weeks, weekly times 8 weeks, bi-weekly times 4 weeks and monthly for 1 month with corrective action and re-education upon discovery.</p> <p>4. The Director of Nursing and or Unit Managers will submit a summary of the audit findings for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director</p>	2/13/16



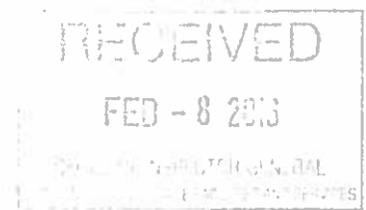
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F 431	Continued From page 92 Interview with LPN #2, on 12/16/15 at 10:25 AM, revealed the unsealed EDK box had to be sealed with a plastic seal that was numerated. LPN #2 stated the number on the seal assured tracking of the times the EDK box had been opened for the facility and pharmacy to assure availability of emergency medications. The nurse stated the number had to be placed on a pharmacy Emergency Box Usage Sheet (EBUS) on the bottom, after resealing the EDK box. LPN #2 continued to state the sheet would be faxed to the pharmacy with the number. Further observation and interview with LPN #2 revealed the EBUS, dated 12/03/15 and collected on 12/16/15 at 10:35 AM, had no seal number recorded.  Interview with the DON, on 12/16/15 at 4:20 PM, revealed she would have expected nurses to follow the process of sealing the EDK box and recording the number of the seal on the pharmacy Emergency Box Usage Sheet. The DON stated she was not aware the nurses were not following the process. The DON stated she only started there in October of 2015 and she was out of the facility for 2 weeks for her training.	F 431	for any additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F 441  1. Residents # 8 and unsampled residents J and K were re-assessed by a Licensed Nurse for signs and symptoms of infection on January 26, 2016. No changes were noted from residents' # 8 and unsampled residents J and K's baseline. Resident # 25 is no longer resides in the facility. LPN # 13 will receive re-education upon return to work by the Unit Manager and or Nurse Practice Educator regarding aseptic technique when providing catheter care and need to check that indwelling catheter drainage bags are covered and off the floor. LPN # 1 received re-education on December 16, 2015 by Unit Manager regarding appropriate hand hygiene during medication pass.	2/13/16



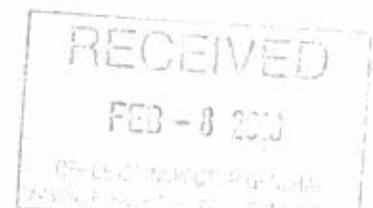
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F 441	<p>Continued From page 93 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews, record review, and review of the facility's policies, it was determined the facility failed to implement their infection control practices to prevent the development and transmission of disease/infection during the medication pass and catheter care for two (2) out of thirty-seven (37) sampled residents, (Residents #8 and #25) and</p>	F 441	<p>2. All residents of the facility have the potential to be affected. The Director of Nursing, Unit Managers and or Nurse Practice Educator completed rounds of all units on January 22, 2016 to determine appropriate hand hygiene was practiced with all residents care to include urinary catheter care using aseptic technique, during medication pass and all residents with urinary catheters were checked to determine indwelling catheter drainage bags are covered and off the floor. Concerns identified were corrected upon discovery.</p> <p>3. The Nurse Practice Educator and or Director of Nursing re-educated the Nursing Department regarding the need to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection including appropriate hand hygiene, urinary catheter care using aseptic technique, and maintaining indwelling catheter drainage bags are covered and off the floor on or before February 12, 2016. A post-test was given at the time of the re-education with a passing score of 95% graded by the Director of Nurses or Nurse Practice Educator to validate understanding of the</p>	2/13/16



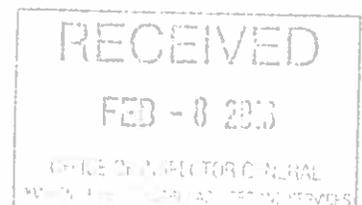
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NAME OF PROVIDER OR SUPPLIER  REGIS WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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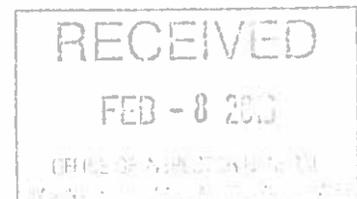
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 94</p> <p>two (2) unsampled residents (Unsampled Residents J and K).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Hand Hygiene, effective since revised on 10/01/13, revealed adherence to hand hygiene practices was maintained by all personnel. This included hand washing with soap and water when hands were visibly soiled and the use of alcohol based hand rubs for routine decontamination in clinical situations.</p> <p>Review of the facility's policy regarding Indwelling Catheter Care, revised 01/02/14, revealed instructions to secure the catheter's tubing and to keep the drainage bag below the level of the patient's bladder and off the floor.</p> <p>Observation of catheter care for Resident #8, on 12/17/15 at 3:25 PM, with Licensed Practical Nurse (LPN) #18 revealed the nurse completed the catheter care using aseptic technique. However, once the cleaning had been completed, the nurse used the same gloves to touch the drainage bag, then touched the resident's arm, leg, bed remote, and call light without removal of soiled gloves and performing hand hygiene. In addition, the nurse washed out the dirty basin used to clean the catheter with the same gloves, touched the drainage bag again, touched the resident's privacy curtain before she removed the soiled gloves and washed her hands with soap and water.</p> <p>Interview with LPN #18 (at the time of the observation) revealed she had not noticed she had kept the soiled gloves on after catheter care</p>	F 441	<p>Information presented. Staff not available during this timeframe including new hires with orientation will complete reeducation with a posttest to validate understanding upon return to work.</p> <p>The Director of Nursing, Unit Manager and or the Nurse Practice Educator will conduct visual observation audits over all three shifts daily times 2 weeks including weekends then 3 times a week for 2 weeks, weekly for 3 weeks, bi-weekly for 8 weeks then monthly for 1 month to ensure that appropriate hand hygiene, urinary catheter care using aseptic technique, indwelling catheter drainage bags are covered and off the floor to prevent the spread of infection. Concerns will be corrected upon discovery.</p>	2/13/16



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F 441	<p>Continued From page 95</p> <p>and touched all those items. She stated she was a little nervous and did not pay attention to details.</p> <p>Additionally, observation of Resident #8, on 12/16/15 at 7:52 AM, revealed the resident sitting on the side of the bed awaiting breakfast. The resident's catheter's drainage bag was laying on the floor. On 12/17/15 at 8:05 AM, observation revealed the drainage bag was again laying on the floor.</p> <p>Interview with Resident #8, on 12/17/15 at 8:07 AM, revealed the drainage bag had been laying on the floor for some time. The resident stated the staff had not instructed him/her to keep the bag off the floor.</p> <p>Interview with Certified Nursing Assistant (CNA) #21, on 12/17/15 at 8:25 AM, revealed he had provided bowel incontinent care for the resident and had noticed the urinary catheter bag laying on the floor. He stated the drainage bag was not supposed to be on the floor. He said this was the first time he had checked on the resident and observed the drainage bag on the floor. He stated it was the policy of the facility to either anchor the drainage bag to the bed or place it in a wash basin.</p> <p>Interview with LPN #18 (Resident #8's nurse), on 12/17/15 at 8:35 AM, revealed she had not looked at the indwelling catheter and had not observed the drainage bag on the floor. She stated catheter drainage bags are supposed to be anchored to the bed frame and off the floor. If on the floor, this could place the resident at risk for infections.</p>	F 441	<p>4. The Director of Nursing and or Nurse Practice Educator will submit a summary of the audit finding monthly for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or in-servicing needs until the issue is resolved and ongoing thereafter.</p>	2/13/16	



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F 441	<p>Continued From page 96</p> <p>Interview with Nursing Facility 2 (NF2) Unit Manager, on 12/17/15 at 8:42 AM, revealed she conducted walking rounds and looks for catheter bags on the floor. She stated Resident #8 would transfer self to the bed from the wheelchair and would not always anchor the catheter bag to the bed. She stated the resident's catheter bag was often observed on the floor and she had to remind the resident to keep it off the floor. She stated each shift was supposed to perform walking rounds and give report to the staff starting the work shift. She stated the resident currently had VRE (Vancomycin Resistant Enterococcus) in his/her urine that required treatment and would be at risk for additional infections if the drainage bag was on the floor.</p> <p>Review of the clinical record for Resident #8 revealed the facility admitted the resident on 07/16/15 with a diagnosis of Neurogenic Bladder with the use of an indwelling catheter. The clinical record revealed the resident was in the hospital from 09/21/15 to 10/11/15 for MRSA (Methicillin-resistant Staphylococcus aureus) in the Urine and Sepsis. The record revealed the resident experienced another UTI (Urinary tract infection) on 11/23/15 that required antibiotic treatment. On 12/10/15, a Urinalysis and Culture revealed the resident had VRE in his/her urine. Intravenous antibiotic medications were ordered and continued through the survey.</p> <p>2. Observation of Resident #25 sitting in a wheelchair in the hallway, on 12/17/15 at 9:40 AM and 1:20 PM, revealed the resident had an indwelling catheter attached to a drainage bag and hung from the wheelchair. The drainage bag was noted to be in direct contact with the floor on</p>	F 441	<p>INTENTIONALLY LEFT BLANK</p>	



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F 441	<p>Continued From page 97 both observations.</p> <p>Interview with Certified Nursing Assistant (CNA) #9, on 12/17/15 at 2:26 PM, revealed indwelling catheter drainage bags were not supposed to be in contact with the floor. She stated she had been trained by the facility that this could cause contamination and the resident could get an infection.</p> <p>Interview with LPN #9, on 12/17/15 at 2:41 PM, revealed indwelling catheter drainage bags could not be in contact with the floor as this could cause a serious infection. She stated staff were trained to ensure safety with catheter use.</p> <p>3. Observation during the medication pass, on 12/16/15 at 8:15 AM, revealed LPN #1 did not practice hand hygiene before, during, or after medication pass between two (2) unsampled residents, Unsampled Resident J and Unsampled Resident K.</p> <p>Interview with LPN #1, on 12/16/15 at 10:20 AM, revealed she did not utilize hand hygiene during the medication pass. The nurse stated she did not wash her hands; however, she knew she should have. The nurse further stated she normally sanitized her hands; however, she confirmed she did not sanitize her hands either.</p> <p>Interview with the Director of Nursing (DON), on 12/16/2015 at 4:06 PM, revealed she expected the nurses to utilize all medication rights, including knocking on doors, explaining medications to residents, administering medications and washing hands. The DON expected nurses to use hand hygiene before and after giving medications, as well as before and</p>	F 441	INTENTIONALLY LEFT BLANK	

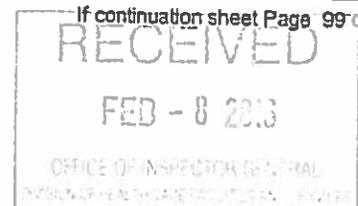
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F 441	Continued From page 98 after contact with any residents.	F 441		
F 520 SS=F	<p>Further interview with the DON revealed that had she known the nurses had not washed or sanitized their hands, this would have provided for a teachable moment. The DON stated the lack of hand hygiene or sanitizing could cause an infection.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p>	F 520	<p>F520</p> <p>A plan of action was developed and implemented by the Quality Improvement Committee to correct identified quality issues and concerns. A Quality Improvement Committee meeting was held on January 7, 2016 to discuss the action plan including audits, education, and compliance monitoring.</p> <p>The Nursing Home Administrator (NHA) conducted an "ad hoc" Quality Improvement Committee meeting on January 4, 2016 to address the identified quality issues cited at F371.</p> <p>The Manager of Clinical Operations or Regional Vice President of Operations re-educated NHA on December 31, 2015 who will re-educate the IDT on the Quality Improvement Committee process on or before January 8, 2016.</p> <p>The governing body will ensure that the facility is administered in a manner that enable it to the use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.</p>	2/13/16



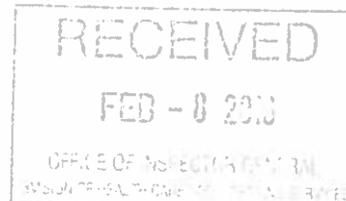
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F 520	<p>Continued From page 99</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and policy review, it was determined the facility failed to meet quarterly to identify issues with respect to deficient practice and to ensure audits were conducted that were included in prior plans of corrections. The facility had been cited at F371 for one (1) Standard survey on 10/30/14 and one (1) Abbreviated survey on 04/30/15. (Refer to F371) In addition, the facility failed to hold Quality Assurance (QA) meetings since 08/15/15.</p> <p>The findings include:</p> <p>Review of the facility's Quality Improvement Process, revised 04/01/03, revealed the facility would implement an ongoing Quality Improvement (QI) Process. The Quality Improvement Committee (QIC) would be composed of the Administrator, Director of Nursing, Medical Director, and Representatives from each department. The QIC would meet at least ten (10) times annually, preferably monthly, to monitor quality within the center, identify issues, and develop and implement appropriate plans of action to correct identified quality deficiencies. The QIC was responsible to review key clinical events, survey results and plans of correction, the process which were known to be high risk, high volume, or problem prone, and are known to jeopardize the safety of customers and complainants.</p> <p>Review of the last Standard survey, dated 10/30/14, revealed the facility was cited for not labeling and dating food items in the refrigerator.</p> <p>Review of the Plan of Correction (POC) from the</p>	F 520	<ol style="list-style-type: none"> <li>1. On December 17, 2015 the Director of Dining Services and/or Executive Chef completed observation of the dietary department to ensure that 1) the floor and equipment were clean; food items were covered, labeled and dated; and refrigerators contained thermometers both in the kitchen and on the units, 2) Dietary staff changed gloves with appropriate handwashing between tasks and staff contained hair and beards in protectors, 3) there were no scoops left in containers or in the ice chest, 4) the garbage can had a lid, and 5) there were Quat chemical test strips available for the three compartment sink and the dishes and carts were completely air dry prior to meal service with corrective action upon discovery.</li> <li>2. All residents of the facility who consume meals prepared from the kitchen have the potential to be affected. On December 17, 2015, the Director of Dining Services and or Executive Chef completed observation of the dietary department to ensure that 1) the floor and equipment were clean; food items were covered, labeled or dated; and</li> </ol>	2/13/16



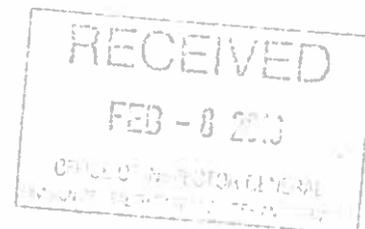
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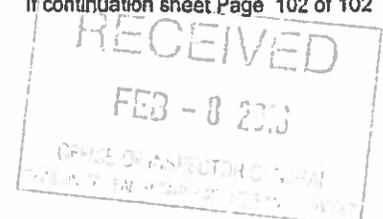
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F 520	<p>Continued From page 100</p> <p>Standard survey, dated 10/30/14, revealed the Dietary Manager would complete sanitation audits, which included the checking of unlabeled food in refrigerators and cleanliness of the kitchen for twenty-four (24) weeks. The audits would be submitted to the QIC for further review and recommendations.</p> <p>Review of a complaint investigation, dated 04/30/15, revealed the facility was not recording the temperatures of food items before service.</p> <p>Review of the Plan of Correction from the Complaint survey, dated 04/30/15, revealed the Dietary Cooks and Servers would complete daily food temperature logs on food bars and hall trays. The Administrator, Assistant Administrator, Dietary Manager would conduct meal service audits, seven (7) days per week for two (2) weeks, three (3) days per week for two (2) weeks, weekly for five (5) weeks and then monthly thereafter. The Administrator would track the results of the audits. Results of the audits would be submitted to the monthly QIC for further review and recommendations for six (6) months.</p> <p>Review of the signatures to the QI meetings, revealed the Administrator had only conducted one (1) QI meeting on 08/10/15. The Administrator was to audit food temperature logs into October of 2015.</p> <p>Observations of the kitchen, on 12/15/15 at 8:10 AM; on 12/16/15 at 11:00 AM; on 12/16/15 at 1:50 PM; of the Rehabilitation Unit on 12/16/15 at 1:30 PM; and, of the ice chest in the dining area on 12/16/15 at 1:45 PM, revealed dirty floors and equipment, spills, thermometers missing in the refrigerators, foods and liquids not covered,</p>	F 520	<p>refrigerators contained thermometers both in the kitchen and on the units, 2) Dietary staff changed gloves with appropriate handwashing between tasks and staff contained hair and beards in protectors, 3) there were no scoops left in containers or in the ice chest, 4) the garbage can had a lid, and 5) there were Quat chemical test strips available for the three compartment sink and the dishes and carts were completely air dry prior to meal service with corrective action upon discovery.</p> <p>On January 28, 2016 The Director of Dining Services and/or Executive Chef provided reeducation to all dietary employees to ensure that the facility would maintain the Food and Nutrition Service Department in a clean and sanitary manner to ensure food and beverages were stored, prepared, and served in a clean and sanitary environment with a posttest completed to validate understanding with a passing score of 95% graded by the Director of Dining Services and/or Executive Chef. Staff not available during this timeframe including new hires with orientation will complete reeducation with a posttest</p>	2/13/16



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F 520	<p>Continued From page 101</p> <p>labeled or dated, and a large garbage can in the kitchen with no lid. Employees did not perform hand hygiene or change gloves between tasks. Kitchen employees did not properly restrain their hair. A scoop was left in a food container. The ice scoop was resting in the ice chest with the ice and there was no holder for the scoop. Staff did not test the sanitation sink for the correct chemical sanitation level with the correct test strips prior to washing pots and pans in the kitchen.</p> <p>Interview with the Administrator, on 12/17/15 at 1:45 PM, revealed he had one only QI meeting since he had been the Administrator. He stated the committee was to review items such as infections, weight loss, and hospitalizations, falls and incidents, housekeeping, maintenance, dietary concerns and any policies and procedures that needed to be addressed. The Administrator stated he had no reason or explanation as to why the QIC had not met. The Administrator stated he had no idea that labeling and dating of food items had been a problem during the 10/30/14 and 04/30/15 surveys. The Administrator stated that label and dating of food was a safety issue for the residents to ensure that the food was not spoiled. The Administrator stated there had not been any signs or symptoms of food borne illness. The Administrator stated he had not completed any of the audits specified in the POC and if he would have had a QI meeting, he would have identified the temperature logs had not been completed as outlined in the plan of correction from the April 2015 Complaint survey.</p>	F 520	<p>provided by the Director of Dining Services or Executive Chef to validate understanding upon return to work.</p> <p>3. The Director of Dining Services and or Executive Chef and or Manager on Duty and or Assistant Administrator will complete audits at each meal service (3 times per day) times 2 weeks to include weekends, then daily times 2 weeks, then 3 times per week for 2 weeks, then weekly for 8 weeks and monthly for 3 months and then as determined by the Quality Improvement Committee to ensure that 1) the floor and equipment are clean; food items are covered, labeled or dated; and refrigerators contain thermometers both in the kitchen and on the units, 2) Dietary staff change gloves with appropriate handwashing between tasks and staff have hair and beards in protectors, 3) there are no scoops left in containers or in the ice chest, 4) the garbage can has a lid, and 5) there were Quat chemical test strips available for the three compartment sink and the dishes and carts were completely air dry prior to meal service with corrective action upon discovery.</p>	2/13/16



4. The Director of Dining Services and or Executive Chef will submit a summary of the audit findings for 6 months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow-up and/or in-servicing needs until the issue is resolved and ongoing thereafter.

2/13/16

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DMSLA TELEPHONE AT 1-800-368-5800

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978, 1980, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III unprotected.</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; hydraulically designed.</p> <p>GENERATORS: Two (2) new, 400 KW, Type II generators, installed in May of 2014, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey, utilizing the 2786S Short Form, was conducted on 12/15/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>The Regis Woods Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed because it is required by federal and state law.</p>	2/13/16



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE 2/5/16

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  12/15/2015
NAME OF PROVIDER OR SUPPLIER  REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
(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	
K 000	Continued From page 1 Fire).	K 000	K 056		
K 056 SS=F	<p>Deficiencies were cited with the highest deficiency identified at an F level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, It was determined the facility failed to ensure the building had a complete sprinkler system in accordance with National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect each of the twelve (12) smoke compartments on the residents, staff, and visitors. The facility has one-hundred and eighty-six (186) certified beds and the census was one-hundred and seventy-seven (177) on the day of the survey.</p> <p>The findings include:</p>	K 056	<p>On January 7, 2016 the Maintenance Director initiated request for quotes to install automatic sprinkler coverage for Entrance A and Entrance B. A scheduled assessment occurred on January 27, 2016 and quote will be obtained on January 29, 2016 by a sprinkler company.</p> <p>All residents of the facility have the potential of being affected. The facility Maintenance Director completed visual observations of both Entrance A and Entrance B on 12/16/2015 with no additional concerns identified. On 1/19/16 the maintenance director audited all entrances per NFPA 13 requirements. No other areas of concerns identified</p> <p>The Regional Property Manager re-educated the Maintenance Director and Maintenance Assistant on 1/19/16 in regards to NFPA 25 19.3.5 requirements for full sprinkler coverage. A posttest was administered to validate understanding.</p> <p>Estimated completion by February 5, 2016. The Property Manager and the Administrator will oversee the project to completion. The Administrator will keep the Life Safety office appraised during this time via email.</p>	2/13/16	

