STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, resident council group interview, review of the facility's policy and procedures, review of facility resident questionnaires, and the Resident Council Minutes it was determined the facility failed to ensure attempts were made to resolve grievances for nine (9) of thirty-seven (37) sampled residents (Residents #8, #14, #16, #17, #24, #32, #33, #35, #36) and three (3) unsampled residents (Unsampled Residents C, D, E). Review of the Resident Council Minutes, dated April, May, June, and July 2014, revealed the residents had complained, of their call bells not being answered timely in the past two (2) months. Interview with Residents #14, #17, #24, #33, #36 and Unsampled Residents C, D, and E during the Group Interview and also individual resident interviews revealed they continued to complain of their call bells not being answered timely. However, review of the facility's documentation regarding grievance forms and call light audits revealed no documented evidence the facility had attempted to resolve the residents' grievances regarding call bells, even though this had been an ongoing concern expressed by residents since April 2014. In addition, during the facility's investigation regarding alleged neglect, eight (8) interviewable residents were interviewed by facility staff (Residents #8, #16, #17, #24, #32, #33, #35 and #36). All eight (8) residents verbalized concerns regarding night shift staff's care, which was documented on the facility's care questionnaire forms utilized during the interviews. The residents expressed concerns related to: problems with their call light not being answered in a timely manner; having to wait for extended periods of time to receive the care requested; not getting their medication as ordered; and not receiving pain medications as ordered or requested. Although the facility's investigation identified those eight (8) residents' concerns regarding care issues, there was no documented evidence the facility investigated and followed-up on the concerns to resolve the residents' grievances. The findings include: Review of the facility's policy titled, Investigating a Resident Grievance or Complaint, dated December 2010, revealed it was the intent of the facility for all grievances and/or complaints to be investigated by the appropriate facility staff and recorded on the grievance/complaint log. Policy review revealed the Administrator would assign the responsibility of investigating grievances and complaints to the Social Services Director (SSD) or designee. According to the policy, all grievances/complaints would be documented on the Grievance and Complaint Report by the person receiving the report, and the SSD or designee would begin an investigation into the allegations. The policy revealed the investigation and report were to include a follow-up/recommendation for corrective action, a resolution, and date of the resolution. Continued review of the policy revealed the Grievance/Complaint Investigation Report was to be reviewed by the Administrator within three (3) working days of the receipt of the grievances or complaint and the resident or person acting on behalf of the resident was to be informed of the findings upon completion of the investigation, as well as, any corrective actions. Further review revealed the grievance or complaint and the corrective action taken were to be documented in the Social Service Progress Notes in the resident's medical record, on the Grievance Complaint Form and noted on the grievance/complaint log. The completed Grievance/Complaint Form was to be maintained on file in the Administrator's office or SSD's office. Review of Resident Council Meeting Notes dated 04/28/14 and 05/20/14, revealed call lights were not being answered promptly and were not being answered around 10:00 PM to 11:00 PM. Further review of the Resident Counsel Meeting Notes, date 07/14/14, revealed residents were hearing personal conversations among State Registered Nursing Assistants (SRNAs) instead of answering call lights, and staff was responding to call lights, but turning the call light off without addressing what the resident's needed. Review of the facility's information regarding complaints/grievances revealed no documented evidence call light concerns were addressed until 06/03/14. Review of the Complaint/Grievance Report form dated 06/03/14, revealed the Resident Council's concerns were addressed by the SSD, and the SSD documented she, along with nursing staff, would audit call lights across all shifts. Further review of the Complaint/Grievance form dated 06/03/14, revealed the resolution, which was undated, noted the facility would continue call light audits until further notice. Review of the facility's call light audits for June 2014 revealed audits were conducted on two (2) shifts, the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts. However, further review of the call light audits revealed there was no documented evidence the audits were conducted on the 11:00 PM to 7:00 AM shift. 1. Interview with residents during the Group Interview conducted on 07/01/14 at 10:50 AM by the State Survey Agency, revealed Resident #14, Resident #17, Resident #24, Resident #33, Resident #36, Unsampled Resident C, Unsampled Resident D, and Unsampled Resident E were present. The residents present stated they have had to wait for an hour or longer for staff to answer their call lights. The residents in the Group Interview stated they were not certain their concern regarding staff answering their call lights in a timely manner was addressed by the facility, even though they had voiced their concern in Resident Council Meetings. Interview with Resident #14 on 07/03/14 at 2:00 PM, revealed the staff were slow to answer the call lights on the weekends. Interview, on 07/01/14 at 11:00 AM, with Resident #17 during the Group Interview revealed he/she had waited for over an hour a lot of times for someone to come and assist him/her after ringing his/her call light. According to Resident #17, staff who were not SRNA's turned off his/her call light and walked away without assisting him/her, or getting someone else to provide assistance. Review of Resident #17's Quarterly Minimum Data Set ((MDS) dated [DATE], revealed the facility assessed Resident #17 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact. Interview, on 07/25/14 at 9:30 AM, with Resident #24 revealed she had problems with call lights not being answered timely. Resident #24 stated it could range from five (5) minutes to an hour for staff to answer it. According to Resident #24, he/she knew the staff got covered up with work at times, and it might take longer then. Per interview, Resident #24 stated he/she took himself/herself to the bathroom, and did not ask staff for help to do that. Continued interview with Resident #24 revealed he/she had complained of the call light issue before in the past; however, indicated he/she could not recall who he/she told. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #26 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #26 as requiring: extensive physical assistance of two (2) staff with his/her Activities of Daily Living (ADLs) of bed mobility, transfers and toileting. Interview with Resident #33, on 07/03/14 at 2:25 PM, revealed it took staff a long time to respond to his/her call light when he/she rang it. Resident #33 reported it was worse at night. Review of the Quarterly MDS assessment dated [DATE] revealed the facility assessed Resident #33 to have a BIMS score of fourteen (14), indicating the resident was cognitively intact. Interview, on 07/24/14 at 2:10 PM, with Resident #36 revealed he/she had to wait twenty (20) to thirty (30) minutes sometimes for his/her call light to be answered. According to Resident #36, he/she thought the facility was really short of staff at night; staff was busy and couldn't get to him/her right away at times. Review of the Quarterly MDS Assessment, dated 06/16/14, revealed the facility assessed Resident #36 to have a BIMS score of fourteen (14) which indicated the resident was cognitively intact. Interview with the Activities Director on 07/03/14 at 3:42 PM, revealed residents in the Resident Council Meetings had voiced concerns about staff taking a long time to answer their call lights. She reported, the residents concerns were filled out on a grievance form and given to the SSD who was supposed to look into

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) the residents' concerns. The Activities Director stated the facility had seventy-two (72) hours to answer a resident's voiced concern and correct the issues. She stated the resolution of the call lights not being answered by staff was addressed with the SSD who was auditing the call lights across all the shifts. Interview with the SSD on 07/03/14 at 4:08 PM, revealed if a concern was brought up in the Resident Council Meetings, then a grievance/complaint form was filled out. She stated if the concern brought up was about a specific department, then she would let that department know about the concern. Continued interview with the SSD revealed the Resident Council had concerns about the call lights not being answered timely, and she developed an audit for call lights to be performed across all shifts and during shift changes. She indicated the majority of call light audits had been done during the day shift, with a few audits conducted by nurses and SRNAs during the 3:00 PM to 11:00 PM shift. However, call light audits had not been completed during the SRNAs 11:00 PM till 7:00 AM shifts. The SSD indicated the call light audits should have been performed during the 11:00 PM to 7:00 AM SRNAs shift though, as the audits were supposed to be performed across all shifts. Interview with the Registered Nurse (RN) #4/Assistant Director of Nursing (ADON) of the South Unit, on 07/03/14 at 4:35 PM, revealed the SSD was responsible for the audits of the call lights and it was reviewed in the facility's Quality Assurance (QA) meetings. RN #4/ADON reported the SSD had audited all shifts and stated she did not participate in the auditing of call lights. She stated she was not aware of nursing staff assisting with the call light audits, as to her knowledge only the SSD was auditing the facility's call light system. Interview with the Staff Development Coordinator (SDC), on 07/03/14 at 6:41 PM, revealed the call light audits were used to observe the amount of time it took for staff to respond to a resident's call light after the resident rang the call light. She reported the audits were done on all shifts. However, there was no documented evidence an audit was completed on the 11:00 PM to 7:00 AM shift. Further interview with the SDC revealed all shifts should have been audited for call light concerns, per the Resident Council's concern. Interview with the Director of Nursing (DON), on 07/03/14 at 5:20 PM, revealed the facility talked to the residents once a week to find out about how staff was doing with answering their call lights. She stated if a concern regarding the call lights came up more often, then she would talk to residents more often related to their concerns. She reported Resident #26 had brought the call light concern of residents having to wait for an hour or more for staff to assist with their care to her attention. The DON stated this was why the facility was continuing with the call light audits. However, there was no evidence the call light audit had been conducted consistently and on all three (3) shifts. Interview with the former Administrator, on 07/03/14 at 7:25 PM, and 07/31/14 at 10:14 PM revealed, she was the Administrator for the facility from 05/15/14 until 07/11/14. The former Administrator stated, the concerns from the Resident Counsel Meetings were to be addressed as a grievance. Further interview revealed, the facility was doing call light audits before she started at the facility, and they were done at varying times by staff; however, she stated she was unsure if the audits were being conducted on the night shift. She stated she did not think the QA effort to improve the timeliness of answering call bells was effective, and had not corrected the problem. 2. Review of the facility's neglect investigation report revealed resident care questionnaire interviews performed with interviewable residents revealed nine (9) interviewable residents expressed concern regarding the care received on night shift. These concerns included: call lights not being answered at night; not receiving care as requested during the night or not having care provided during the night; not receiving assistance to get out of bed, go to the bathroom or be changed during the night; and, not receiving pain medication as requested or ordered, or not receiving medications as requested or ordered. The residents included, Resident #8, Resident #16, Resident #17, Resident #24, Resident #26, Resident #32, Resident #33, Resident #35 and Resident #36. However, review of the facility's investigation report revealed no documented evidence the interviewable residents' concerns were investigated and resolved. Interview, on 07/25/14 at 11:20 AM, with Resident #8 revealed although he/she was continent, he/she required assist of one (1) staff to go to the bathroom. Per interview, Resident #8 stated at during the night shift there were not enough staff and there were issues due to staffing. Resident #8 indicated he/she did not recall anyone following up with him/her regarding concerns made on 07/03/14. Review of the Quarterly MDS Assessment, dated 03/30/14, revealed the facility assessed Resident #8 to have a BIMS score of fifteen (15) which indicated no cognitive impairment. Interview, on 07/24/14 at 1:30 PM, with Resident #16 revealed he/she usually went to the bathroom on his/her own; however, required assistance to get out of bed. According to Resident #16, he/she had told a nurse about having to wait forty-five (45) minutes for the call light to be answered, but couldn't recall the nurse's name. Resident #16 revealed he/she recalled the facility's Chaplain asking him/her questions about the care before; however, did not recall anyone following up on his/her concerns expressed. Review of the Significant Change MDS Assessment, dated 05/05/14, revealed the facility assessed Resident #16 to have a BIMS score of fifteen (15) which indicated no cognitive impairment. Additional interview, on 07/24/14 at 1:49 PM, with Resident #17 revealed someone had interviewed him/her regarding concerns he/she had with care on 07/03/14; however, the resident stated no one had followed up with him/her on the concerns expressed. Per interview, Resident #17 stated he/she had still had to wait on his/her call light to be answered for as long as thirty (30) minutes at times. According to Resident #17, he/she felt the nurses should be on top of call lights and know how long they had been on. Further interview, on 07/25/14 at 9:30 AM, with Resident #24 revealed on 07/03/14, he/she told the SSD of his/her concern about not getting his/her pain medication on 06/27/14 after requesting it three (3) times; however, as of 07/25/14, there had been no follow-up with the resident regarding the concern. Interview with Resident #32, on 07/22/14 at 5:00 PM, on 07/25/14 at 3:30 PM and on 07/31/14 at 6:25 PM, revealed he/she had talked to the people over the building previously, but he/she still had to wait for the call light to be answered on day shift and night shift, and he/she still wet on himself/herself. The resident stated nothing had been done, and he/she felt staff did not respond to his/her call light in a timely manner. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14) which indicated no cognitive impairment. Additional, interview with Resident #33 on 07/29/14 at 6:30 PM, revealed staff had talked to him/her regarding concerns with night shift; however, no one had followed up with him/her on his/her concerns. Interview with Resident #35 was not conducted as the resident had been discharged and was in the hospital. However, review of Resident #35's care questionnaire completed by the SSD on 07/03/14, during the facility's investigation, revealed the resident expressed concern regarding not receiving his/her pain medication and other medication the night before. Review of the 07/09/14 MDS Assessment, revealed the facility assessed Resident #35 to have a BIMS score of fifteen (15) which indicated the resident was cognitively intact. Further interview, on 07/24/14 at 2:10 PM, with Resident #36 revealed the resident recalled the care questionnaire interview performed on 07/03/14; however, expressed he/she did not recall staff had followed-up in regards to his/her concerns related to call lights and staffing. Interview with the SSD on 07/23/14 at 5:49 PM, revealed when she received grievances or concerns, these were given to the Department Head, and if it had anything to do with nursing it was given to the DON, as the facility used a team approach. She stated on 07/03/14 she, the Activities Director, Chaplain, and Supply Coordinator had performed interviews with interviewable residents that day. According to the SSD, they had identified resident concerns with call bells, and she had ensured call bell audits were being done on the day and evening shift, then after 07/03/14, she had assured the call bell audits were being conducted on all shifts to include the 11:00 PM to 7:00 AM shift. She stated she looked over the call bell audits and noted whether there were any complaints. Additional interview on 07/25/14 at 7:20 PM, with the SSD revealed the call bell audits were initiated a few months ago, and the audits were part of the facility's Quality Assurance (QA) process. The SSD stated as the audits were part of the QA she should have been ensuring they were completed on all shifts when they were first initiated. She revealed she had not investigated the other interviewable residents' concerns from the interviews conducted on 07/03/14, until the survey was re-opened on 07/22/14, and the State Survey Agency began interviewing about the concerns. The SSD stated she had not addressed the concerns as grievances and written the concerns up on grievance forms. She indicated she was not sure why she hadn't addressed the residents concerns at the time of the investigation. The SSD stated she assumed the former Administrator talked to the DON about the complaints received from other interviewable residents after the interviews were conducted on 07/03/14. In addition, she indicated as she had not addressed the residents' concerns as grievances, she had not documented anything in their records. However, review of the facility's Investigating a Resident Grievance or Complaint policy revealed the Administrator would assign the responsibility of investigating grievances and complaints to the SSD or designee, and the SSD or designee would begin an investigation into the allegations. The Policy noted the SSD or designee would include in the investigation: the date and time of the incident reported; the nature of the grievance or complaint; the name of any witnesses and their account of the incident; the resident's account of the incident; follow-up/recommendation for corrective action; a resolution; and date of the resolution. Further review revealed the grievance or complaint and the corrective action taken were to be documented in the Social Service Progress Notes in the resident's medical record, on the Grievance Complaint Form and noted on the grievance/complaint log. The completed Grievance/Complaint Form was to be

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F 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) maintained on file in the Administrator's office or SSD's office. Interview on 07/25/14 at 7:20 PM, with the HR Director revealed she and the SSD took direction from the former Administrator who had not directed them to follow-up on those concerns received on 07/03/14. The HR Director stated the former Administrator had not told her or the SSD if she had followed-up on the residents' concerns either. She stated there had been miscommunication between the three (3) of them, the former Administrator, herself and the SSD. Further interview with the former Administrator on 07/03/14 at 7:25 PM, and 07/31/14 at 10:14 PM revealed if there was a grievance, a Grievance Form was to be completed and the form would be brought to the morning meeting and discussed and then forwarded to the appropriate department head to investigate. She further stated there was an area on the Grievance Form for findings and conclusions and the corrective action was to be addressed with the person who had the grievance or concern. However, there was no documented evidence this process had been followed. She stated she had not read the resident interviews, as it was verbally reported to her there had been no other resident complaints. The former Administrator stated she had not read the investigation report, and the SSD and Activities Director had conducted resident interviews and verbally reported back to her. Further interview with the former Administrator revealed if residents had verbalized concerns during the interviews conducted as part of the investigation, the concerns should have been followed-up on by staff. Interview, on 07/25/14 at 8:09 PM, with the Special Projects Administrator for the corporation who owned the facility, revealed the facility should have followed-up on any complaints from residents identified during the facility's investigation.
F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on interview, record review, and review of the facility's policy, during the 08/01/14 survey, it was determined the facility failed to ensure residents were free from neglect for five (5) of thirty-seven (37) sampled residents (Residents #5, #26, #27, #28, #29). The facility failed to have an effective system in place to ensure the necessary care and services related to incontinence care were provided to residents when needed and upon the residents' request. On 07/03/14, Resident #26 rang the call bell for incontinence care assistance at approximately 5:30 AM; however was not assisted until approximately 7:45 AM, (two hours and fifteen minutes later). Interview with the day shift State Registered Nursing Assistant (SRNA), who assisted Resident #26 at 7:45 AM, revealed the resident was soaked with urine and covered in bowel movement. Staff interviews further revealed other residents were also left soaked in urine or soiled with bowel movement the morning of 07/03/14, after day shift reported to work at 7:00 AM. These residents included #5, #27, #28, and #29. After becoming aware of this information on 07/03/14, the facility initiated an investigation and identified a conflict between the two (2) SRNAs normally scheduled on the South Unit who didn't work together to provide care. However, the facility failed to address the interviewed residents' concerns with night shift and failed to address the conflict between the two (2) SRNAs assigned to the unit on the night shift which impacted resident care and left residents at risk for further neglect. (Refer to F-225 and F-226) The facility's failure to have an effective system to ensure residents were protected from neglect was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 07/25/14, and was determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure necessary care and services are provided in regards to having an effective system in place to ensure incontinence care is provided timely and upon request and residents are protected from neglect. The findings include: Review of the facility's policy titled, Abuse, Neglect and Misappropriation, dated April 2013 revealed abuse and neglect of residents was prohibited. Review of the facility's Job Description for the position of SRNA, updated December 2011, revealed licensed nursing personnel were to provide supervision of SRNAs when they performed direct resident care duties. Review of the Job Description revealed SRNA's essential duties and responsibilities included the provision of personal care required by residents daily and as needed. 1. Review of Resident #26's medical record revealed the facility admitted the resident on 07/23/12, with [DIAGNOSES REDACTED]. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #26 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #26 as requiring: extensive physical assistance of two (2) staff with his/her Activities of Daily Living (ADLs), with bed mobility, transfers and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder and as being at risk for developing pressure ulcers. Review of the Brand Scale for Pressure Sore Risk, dated 06/23/14 revealed the resident was assessed as having a moderate risk for pressure development. Review of Resident #26's Comprehensive Care Plan, dated 06/16/14, revealed the resident was care planned for ADL assistance and for the potential for altered skin integrity. Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed on 07/03/14, during the night shift he/she had pooped on himself/herself. Resident #26 stated he/she had requested assistance from SRNA #19, who had been assigned to his/her care during the night shift, and SRNA #19 had not assisted with changing the resident after the request. Resident #26 started crying during the interview and stated he/she felt that staff did not want to change him/her and felt he/she wasn't supposed to be clean. Per interview, Resident #26 stated he/she had to wait until day shift came in to get incontinence assistance and get cleaned. Further interview revealed at times he/she had waited for over an hour for staff to answer his/her call light. Resident #26 reported he/she had problems with getting staff to answer his/her call light on the night shift, 11:00 PM to 7:00 AM, and the day shift, 7:00 AM to 11:00 PM. Interview, on 07/03/14 at 7:00 PM, with Registered Nurse (RN) #6, who had worked the night shift from 07/02/14 at 11:00 PM to 07/03/14 at 7:00 AM, revealed at about 5:30 AM, Resident #26 had requested staff's assistance to get cleaned and changed. Per interview, RN #6 stated she informed SRNA #19 to change Resident #26 as the resident was on intravenous (IV) fluids at seventy-five (75) cc's (cubic centimeters) per hour and this caused the resident to urinate a lot. RN #6 stated SRNA #19 told her she was getting the residents up, dressed and ready for breakfast and she needed assistance to change Resident #26. According to RN #6, there was a personal conflict between SRNA #19 and SRNA #21, who were the SRNAs regularly scheduled on the unit. According to RN #6, she had assisted SRNA #19 with resident care at approximately 1:30 AM and 3:00 AM. However, RN #6 was passing medication when Resident #26 requested assistance at approximately 5:30 AM and had not assisted SRNA #19 to change the resident. Continued interview revealed the personal conflict between SRNA #19 and SRNA #21 had negatively impacted resident care that night. RN #6 stated, as she was SRNA #19's supervisor, she should have informed SRNA #19 not to get residents out of bed as that was not as important as providing resident care as requested and/or needed. She stated even though she knew Resident #26 had requested assistance, she did not ensure it was provided; however, should have followed up to ensure the resident's needs were met. Further interview with RN #6 revealed it would be terrible to be wet or soiled and not be changed. She indicated the facility provided training on neglect as a form of abuse, and by not providing the care Resident #26 requested that morning it was neglect. RN #6 stated she had not reported this information to Administration; however, indicated she should have reported the incident. Interview, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, with SRNA #19 revealed early in the morning of 07/03/14, during her last rounds, Resident #26, who was a two (2) person assist, rang the call light and requested incontinence assistance. Continued interview with SRNA #19, revealed she informed Resident #26 as soon as she could get someone to help her she would change him/her. However, she stated she could not get anyone to help her change Resident #26. SRNA #19 stated she asked RN #6 to help her, but she couldn't as she was passing medications. She also asked SRNA #21; however, SRNA #21 ignored her. According to SRNA #19, when SRNA #9 and SRNA #6 came to work on the day shift, somewhere around 6:45 AM to 7:00 AM, she told them Resident #26 needed to be changed. SRNA #19 stated she took out her trash after telling the day shift SRNAs and went home without returning to Resident #26's room. Interview with SRNA #9,

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) on 07/03/14 at 2:44 PM and on 07/23/14 at 1:52 PM, revealed upon reporting to work at 7:00 AM that morning she had discovered Resident #26 had soiled himself/herself and needed to be cleaned and changed. According to SRNA #9, she had asked SRNA #19, who had been assigned to the residents on night shift, to assist with cleaning and changing the resident. She stated however, SRNA #19 did not assist and walked away. She stated SRNA #20, who had come in early that morning to escort Resident #26 to an appointment, had cleaned and changed the resident upon arrival. Interview, on 07/03/14 at 2:51 PM and on 07/23/14 at 2:26 PM, with SRNA #20 revealed she had reported to work early the morning of 07/03/14 to escort Resident #26 to his/her doctor's appointment. She stated upon her arrival, Resident #26 had bowel movement on his/her clothing and on the pad of the reclining chair the resident was sitting on. Per interview, she had to work for over an hour to assist the resident in getting cleaned. According to SRNA #20, Resident #26 usually requested assistance when he/she needed it, and this was not normal for the resident. SRNA #20 stated Resident #26 normally knows when he/she has to have a bowel movement and goes to the bathroom in the wheelchair with two (2) person assist to stand and transfer. She stated Resident #26 told her the aide assigned to his/her care had not checked on him/her all night on 07/02/14 at 11:00 PM to 07/03/14 at 7:00 AM. Additional interview, with SRNA #20 revealed she reported the condition she had found Resident #26 in on 07/03/14 to LPN #8, and had asked her to come look at the resident; however, LPN #8 could not come right then. Interview, on 07/03/14 at 5:53 PM, with Licensed Practical Nurse (LPN) #8 revealed SRNA #20 also told her Resident #26 was left wet. LPN #8 revealed when she went to Resident #26's room and spoke to him/her, the resident told her staff had not been in his/her room all night. Interview, on 07/23/14 at 5:27 PM, with SRNA #16 revealed she had sat with Resident #26 early in the morning on 07/03/14. She stated Resident #26 needed to be changed and she was on light duty and could not change the resident. SRNA #16 stated she told SRNA #19 Resident #26 needed to be changed, and SRNA #19 informed her she would change Resident #26 when she got some help. Interview, on 07/23/14 at 3:49 PM, with RN #4/ADON revealed she had became aware of a problem with night shift late in the day on 07/03/14. RN #4/ADON stated she had overheard SRNA #9 talking to someone else about Resident #26 being left wet that morning. She stated she could not recall who SRNA #9 was telling, and stated SRNA #9 did not tell her directly about Resident #26. RN #4/ADON stated she did not talk to SRNA #9 about what she had overheard her saying; however, indicated she should have. According to RN #4/ADON, she talked to SRNA #16, as she knew she had been sitting with Resident #26 the morning of 07/03/14. She stated SRNA #16 told her SRNA #19 told Resident #26 he/she would have to wait for day shift to come in to change him/her. Interview, on 07/03/14 at 6:45 PM, with RN #5/Evening Shift Supervisor revealed at approximately 4:08 PM that day she had spoken with Resident #26 who told her SRNA #19 had left him/her wet and with crap on him/her. RN #5/Evening Shift Supervisor stated she went to the Director of Nursing (DON) and Social Services Director (SSD) and reported to the DON and SSD what Resident #26 had told her. Per interview, RN #5/Evening Shift Supervisor revealed staff should not knowingly leave residents wet and soiled as that would be a form of neglect. Further interview with SRNA #9, 07/03/14 at 2:44 PM, revealed several other residents were found soaked with urine or soiled on 07/03/14 which included Residents #5, Resident #27, Resident #28, and Resident #29. 2. Review of Resident #5's medical record revealed the facility readmitted the resident on 04/10/14, with [DIAGNOSES REDACTED]. Review of Resident #5's Quarterly MDS Assessment, dated 05/15/14, revealed the facility assessed the resident as having severe cognitive impairment, and to require extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers and toileting. Further review of the MDS Assessment revealed the facility assessed Resident #5 to always be incontinent of bowel and bladder. Continued review of the MDS revealed the resident was assessed as being at risk for pressure ulcers and as having a pressure ulcer. Review of the Brand Scale for Pressure Sore Risk, dated 05/15/14 revealed the resident was assessed as having a moderate risk for pressure. Continued record review revealed Resident #5 had a history of [REDACTED]. Review of Resident #5's Comprehensive Care Plan, dated 06/03/14, revealed the resident was care planned as requiring extensive assistance with bed mobility and for the potential for complications related to his/her incontinence of bowel and bladder. Continued review of the Comprehensive Care Plan revealed the resident was at risk for developing skin breakdown. Review of the interventions revealed treatments were provided from 04/11/14 through 05/26/14 at which time the Stage II was noted as being healed. Additional interview, on 07/23/14 at 12:05 PM, with LPN #8 revealed SRNA #9 had come to her the morning of 07/03/14 and reported Resident #5 being soiled. She stated she had told SRNA #9 to clean and change the resident immediately. Per interview, LPN #8 stated when she went to Resident #5's room, the resident was pretty wet but she could not recall if the bed was wet. 3. Review of Resident #27's medical record revealed the facility admitted the resident on 06/14/13, with [DIAGNOSES REDACTED]. Review of Resident #27's Quarterly MDS Assessment, dated 05/21/14, revealed the facility assessed the resident to have severe cognitive impairment, and to require extensive physical assistance of two (2) staff with his/her ADLs including transfers, bed mobility and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder and as being at risk for developing pressure sores. Review of the Braden Scale for Pressure Sore Risk, dated 05/21/14 revealed the facility assessed the resident as being at a high risk for pressure sore development. Review of Resident #27's Comprehensive Care Plan, dated 05/28/14, revealed the resident was care planned for ADLs and for the potential for complications related to his/her incontinence of bowel and bladder. Continued review of the Comprehensive Care Plan revealed Resident #27 was care planned for the risk of developing skin breakdown and as needing extensive/total assistance with bed mobility. 4. Review of Resident #28's medical record revealed the facility admitted the resident on 03/06/13, with [DIAGNOSES REDACTED]. Review of Resident #28's Quarterly MDS Assessment, dated 03/26/14, revealed the facility assessed the resident to have severe cognitive impairment, and to require extensive physical assistance of two (2) staff for most ADLs including transfers and bed mobility and extensive assist of one (1) staff for toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder and as having no pressure but as being at risk for skin break down. Review of Resident #28's Comprehensive Care Plan, dated 06/03/14, revealed the resident was care planned for ADLs and for the potential for complications related to his/her incontinence of bowel and bladder and for the potential for altered skin integrity. Review of the Pressure Ulcer Braden Scale, dated 06/26/14 revealed the facility assessed the resident to be at moderate risk for skin breakdown. 5. Review of Resident #29's medical record revealed the facility admitted the resident on 09/28/12, with [DIAGNOSES REDACTED]. Review of Resident #29's Quarterly MDS Assessment, dated 07/07/14, revealed the facility assessed the resident to have severe cognitive impairment, and to require extensive physical assistance of two (2) staff with ADLs including transfers, bed mobility and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be always incontinent of bowel and bladder and as being at risk for the development of pressure ulcers. Review of the Braden Scale for Predicting Pressure Sore Risk, dated 07/07/14 revealed the facility assessed the resident as having a mild risk for the development of pressure sores. Review of Resident #29's Comprehensive Care Plan, dated 06/01/14, revealed the resident was care planned for ADLs and for the potential for complications related to his/her incontinence of bowel and bladder. Continued review of the Comprehensive Care Plan revealed the resident was care planned for the potential for altered skin integrity related to decreased physical and cognitive function. Additional interview, on 07/03/14 at 5:53 PM, with LPN #8 revealed on the morning of 07/03/14, after reporting to work at 7:00 AM, SRNA #32 came and got her to look at the condition Resident #29 had been left in by night shift. LPN #8 stated Resident #29 was beyond soaked that morning, and indicated it appeared as though the resident had not been changed at all during the night. Interview, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, with SRNA #19 revealed she had not been able to perform incontinence care on Resident #29 during her last rounds on 07/03/14 as he/she was also a two (2) person assist. Continued interview with SRNA #19, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, revealed there was a conflict between her and SRNA #21 who wouldn't talk to her, and they did not work well together because of this. Per interview at times she had worked the entire South Unit by herself due to SRNA #21 not wanting to work with her. SRNA #19 stated she had informed the nurses and they were aware of the conflict; however, nothing had been done. Further interview with SRNA #19 revealed neglect was a form of abuse, and it was neglect for residents not to be changed when needed. However, SRNA #19 denied leaving residents wet or soiled, not changed, or unattended. Interview, on 07/23/14 at 4:36 PM, with SRNA #21 revealed she worked on the South Unit. She stated SRNA #19 had not requested her assistance early in the morning of 07/03/14. SRNA #21 stated she and SRNA #19 did not have a very good relationship. She stated SRNA #19 did not want to work with her, thought she did not like her, and would not ask her for assistance. SRNA #21 reported SRNA #19 told everyone she refused to help her; however, indicated she assists if SRNA #19 asked her. Continued interview with SRNA #21 revealed SRNA #19 would ask the nurses or SRNAs on the North Unit to help her. SRNA #21 stated she just liked to get her work done on her hall and did not socialize a lot. SRNA #21 indicated if residents were not being changed, ringing their call light for assistance or being left wet it would be abuse in the form of neglect. She stated no one wants to be left wet. Per interview, SRNA #21 stated if SRNA #19 asked her for assistance she would help her.

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) Interview, on 07/29/14 at 3:20 PM, with SRNA #31 revealed staff was aware of the conflict between SRNA #19 and SRNA #21 which had been going on for months. SRNA #31 stated SRNA #19 and SRNA #21 complained about each other to other people. Per interview, SRNA #31 stated he/she had not told nurses or other supervisory staff about it. Interview, on 07/30/14 at 2:55 PM, with SRNA #18 and SRNA #20 revealed they were both aware of the conflict between SRNA #19 and SRNA #21. SRNA #20 stated when SRNA #19 and SRNA #21 worked at night they did not work together and did not answer call lights for each other. Both SRNAs stated everybody knew about the conflict between the two (2) SRNAs and indicated the conflict impacted resident care. SRNA #20 stated there had been times SRNA #19 had left residents soaking wet and with bowel movement on them at the end of her shift. According to SRNA #20, there was no need to tell nurses about the conflict because they knew what was going on. Interview, on 07/24/14 at 9:11 PM with SRNA #4 who worked day shift, revealed she had rounded before on residents who SRNA #19 had been assigned to provide care and had found five (5) residents wet, with their full bed wet with urine, which required a complete bed linen change. She stated she did not report this to anyone as she was not usually assigned to work the South Unit. Further interview, on 07/03/14 at 5:53 PM, with LPN #8 revealed she had noticed when a certain SRNA, whose name she could not recall, worked it looked as if rounds were not being performed on night shift. Per interview, LPN #8 revealed she did not tell her supervisor about what Resident #26 had told her, or of the condition other residents had been left in, as she had observed SRNA #9 going to the Staff Development Coordinator (SDC) to tell her about the condition residents had been left in that morning. Further interview with SRNA #9, 07/03/14 at 2:44 PM, revealed she was so upset over the condition the residents had been left in, on 07/03/14 by SRNA #19, she went to the SDC to report the residents being left soaked and soiled. Additional interview with SRNA #9 revealed when she reported the incident of residents being left soaked and soiled to the SDC on the morning of 07/03/14, the SDC told her to write it up and she would take it to the Human Resources (HR) Director. However, SRNA #9 stated she never wrote up the incidents. SRNA #9 stated almost daily when she came to work after SRNA #19 had worked the previous shift, she found her residents wet and their beds needing to be changed. Per interview, SRNA #9 stated it was neglect to leave residents wet. Interview, on 07/03/14 at 6:41 PM, with the SDC revealed no staff had reported to her that morning the condition residents had been left in, nor had she spoken to residents. However, interviews with SRNA #9 and LPN #8 revealed SRNA #9 had reported the residents' condition to her. The SDC stated if she had been informed of a reportable situation by staff she would have directed them to tell the Assistant Director of Nursing (ADON) and follow the chain of command. Interview, on 07/03/14 at 2:51 PM and on 07/23/14 at 2:26 PM, with SRNA #20 revealed when reporting to work on day shift at 7:00 AM, in a week's time she had had to change several residents three (3) times out of the week. Further interview with SRNA #20 revealed she had told Registered Nurse (RN) #4/Assistant Director of Nursing (ADON) of her concern regarding residents' care. She reiterated three (3) to four (4) days out of the week finding residents wet when she reported to work at 7:00 AM. Interview, on 07/03/14 at 4:35 PM and on 07/23/14 at 3:49 PM, with the RN #4/ADON revealed she was not aware of the incidents involving Resident #5, Resident #26, Resident #27, Resident #28 and Resident #29 which had taken place the morning of 07/03/14 until later that day. She stated a staff member did tell her residents had not been touched in awhile; however, the staff person did not tell her which residents were involved and to what extent. The ADON stated her expectation was for night shift and day shift to do rounds on residents prior to night shift leaving the facility. She indicated staff should not leave residents soiled. Interview, on 07/03/14 at 5:20 PM, with the Director of Nursing (DON) revealed she was not made aware of Resident #26 and the other residents having been left wet and soiled by night shift for day shift to change until about an hour before the current interview with the State Survey Agency. The DON stated an investigation had been started regarding the incident after she was notified. She stated the RN Evening Shift Supervisor notified her. Continued interview with the DON revealed residents should not be left wet and soiled by any shift. Interview, on 07/03/14 at 7:25 PM, with the Administrator revealed it was her expectation staff would ensure residents were clean and dry. She stated staff should be completing rounds every two (2) hours as per the facility's policy. The Administrator stated for residents who need it, rounds should be completed more frequently. Continued interview with the Administrator revealed if a resident was fully saturated with urine, then the employee should be removed from duty and a full investigation initiated to determine if there was a neglect related to the resident's care. The Administrator stated she would have wanted to have been notified that morning when the incident involving the residents had occurred. The Administrator indicated any form of abuse or neglect of residents should be reported to Administration immediately and residents being left soiled was a form of neglect. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 that alleged removal of the IJ effective 07/29/14. Review of the AOC revealed the facility implemented the following: 1. The facility opened and investigated the five (5) reported allegations of neglect identified on the 06/30/14 through 07/03/14 Survey for Residents #5, #26, #27, #28, and #29. Initial Reports were completed with the five (5) day follow up reports pending completion of the investigations. The allegations were investigated by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant. 2. One hundred percent (100%) of the resident population received head to toe assessments by the DON, the ADON, MDS Coordinator, Wound Care Nurse, SDC, Evening Nurse Supervisor, Corporate Nurse Consultant and Charge Nurses on 07/23/14. 3. Residents with a BIMS of eight (8) or above were interviewed by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Supply Coordinator, Quality of Life Director or Chaplain which was completed on 07/25/14 for any abuse, neglect, or misappropriation concerns. 4. Families and responsible parties were interviewed for residents with a BIMS below eight (8) which was initiated on 07/25/14 and as of 07/28/14, thirty-seven (37) of fifty-six (56) had been completed, for any abuse, neglect, or misappropriation concerns. The facility would continue to attempt contacting families and responsible parties daily to identify any concerns until remaining Power of Attorney's (POA's) had been reached. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. 5. Staff was interviewed for any abuse, neglect, or misappropriation concerns by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Quality of Life Director or Chaplain on 07/25/14. Initial reports were made on the allegations relative to those interviews. 6. Initial Reports were made on 07/25/14 related to the alleged allegations relative to the interviews with residents, families, responsible parties, and staff. Thorough investigations were initiated on 07/25/14 by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant on those residents identified with appropriate follow up reporting on the allegations received. 7. Abuse, neglect and misappropriation audits, assessments, interviews and questionnaires were reviewed by the Special Projects Administrator, DON, Corporate Nurse Consultant or Chief Nurse Executive on 07/27-07/28/14 for any indications of abuse, neglect or misappropriation concerns. 8. The Medical Director was notified of the Immediate Jeopardy on 07/25/14 by the DON and Special Projects Administrator. An Emergency Quality Assurance (QA) Meeting was held on 07/26/14 with the Corporate Director of Risk Management, Clinical Nurse Executive, Corporate Nurse Consultant, Medical Director, Special Projects Administrator, DON, HR Director, SSD and SDC related to the Immediate Jeopardy. 9. The DON, two (2) ADONs, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions, Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse were re-educated on 07/23/14 and the Administrator was re-educated on 07/28/14, upon his return, by the Corporate Nurse Consultant on the Abuse, Neglect and Misappropriation Policy and Procedure which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans. They could not return to work until the abuse, neglect, misappropriation education was provided and post test administered and a one hundred percent (100%) score was obtained on the post test. If a manager did not score a one hundred percent (100%) on post test, the manager was immediately re-educated and a post test was re-administered. 10. The facility's Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse educated stakeholders related to the Abuse, Neglect, and Misappropriation Policy which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans starting on 07/23/14 and continued until 07/28/14. No staff would be allowed to work until this education was provided and the post test administered and a one hundred percent (100%) score obtained. Eighty-seven (87) of ninety-six (96) were completed by 07/28/14. 11. Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) Nurse provided education to stakeholders which was initiated on 07/26/14 to nursing staff related to incontinence care and Activities of Daily Living (ADL's) care per the Care Plan and answering call lights. Calls and certified letters had been sent notifying staff they must complete training before returning to work relative to incontinence care and Activities of Daily Living (ADL's) Care per resident individualized Care Plan and answering call lights in a timely manner. 12. Education regarding the Abuse, Neglect and Misappropriation Policy would be included in the orientation process for newly hired staff. No newly hired person w
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on interview, record review, review of the facility's policy and investigation reports, during the 08/01/14 survey, it was determined the facility failed to have an effective system in place to ensure all allegations of abuse, including neglect, were investigated thoroughly to ensure residents were protected from further neglect for five (5) of thirty-seven (37) sampled residents (Residents #5, #26, #27, #28, #29). (Refer to F-224) On 07/03/14, Resident #26, who resided on the South Unit, rang the call bell for incontinence care assistance at approximately 5:30 AM; however was not assisted until approximately 7:45 AM, (two hours and fifteen minutes later). Interview with the day shift State Registered Nursing Assistant (SRNA), who assisted Resident #26 at 7:45 AM, revealed the resident was soaked with urine and covered in bowel movement. Staff interviews further revealed other residents on the South Unit were also left soaked in urine or soiled with bowel movement the morning of 07/03/14, after day shift reported to work at 7:00 AM. These residents included #5, #27, #28, and #29. Review of the facility's investigation revealed only Resident #26's concern and his/her condition on the morning of 07/03/14 was investigated. There was no documented evidence the facility investigated the conditions of Residents #5, #27, #28 and #29 who reportedly had been left urine soaked and soiled the morning of 07/03/14 and no documented evidence an assessment was performed on Residents #5, #27, #28 and #29, who were assessed by the facility as non-interviewable. In addition, the facility failed to assess other non-interviewable residents on the South Unit for possible neglect through skin assessments and failed to interview all staff who had knowledge of the condition the residents were found in, on 07/03/14 at shift change. Additionally, review of the facility's investigation reports revealed a staff interview which indicated a conflict between SRNA #19 and SRNA #21, who were usually scheduled as the night shift SRNAs for the South Unit, on which all the aforementioned residents resided. Even though the conflict was noted in Registered Nurse (RN) #4's/Assistant Director of Nursing's (ADON) written statement in the facility's investigation, there was no documented evidence the facility investigated and interviewed the two (2) SRNAs about the conflict after becoming aware of it during the investigation, or that the facility followed-up and addressed the conflict issue to ensure residents were protected from possible further neglect. Staff interviewed by the State Survey Agency revealed the conflict impacted resident care during the night shift on the South Unit on 07/03/14. The facility's failure to have an effective system in place to ensure all allegations of abuse, including neglect were investigated thoroughly, and to ensure residents were protected from further neglect was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 07/25/14, and was determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure an effective system is in place to ensure all allegations of abuse, including neglect are investigated thoroughly, and residents are protected from further neglect. The findings include: Review of the facility's policy titled, Abuse, Neglect and Misappropriation, dated April 2013 revealed abuse and neglect of residents was prohibited. Review of the Policy revealed staff was to be trained on abuse to include what constituted abuse, neglect or misappropriation of resident property. The Policy revealed all allegations of abuse were to be investigated, and the Administrator/designee was to make all reasonable efforts to investigate and address alleged reports, grievances and concerns. Further review revealed Social Services or the Chaplain were to follow up with the resident to monitor his/her emotional well-being after an incident, and families were to be notified of the outcome of the investigation. Interview, 07/03/14 at 2:26 PM, with Resident #26 revealed early that morning the resident had requested night shift SRNA #19's assistance to get cleaned up as he/she had pooped on himself/herself. According to Resident #26, SRNA #19 did not assist him/her as requested , which made the resident feel staff did not want to change him/her and feel like he/she wasn't supposed to be clean. Resident #26 was observed to start crying, and stated he/she did not received assistance to be changed until after day shift SRNAs came to work. Interview with SRNA #9 on 07/03/14 at 2:44 PM, revealed when she reported to work for day shift on 07/03/14, she found several residents soaked and/or soiled, and needing to be changed (Residents #5, #26, #27, #28, and #29). Review of the facility's investigation reports, dated 07/03/14 through 07/07/14, revealed only Resident #26's concerns were investigated. There was no documented evidence of Resident #5, Resident #27, Resident #28 or Resident #29 being left wet and/or soiled by night shift staff on 07/03/14 was investigated. Continued review of the investigation report revealed Resident #26 was interviewed on 07/03/14 and had concerns about the care received by night shift staff which he/she had reported to Registered Nurse (RN) #5/Evening Shift Supervisor. Interview, on 07/03/14 at 6:45 PM, with RN #5/Evening Shift Supervisor revealed at approximately 4:08 PM that day she had spoken with Resident #26 who told her SRNA #19 had left him/her wet and with crap on him/her. RN#5/Evening Shift Supervisor stated she went to the Director of Nursing (DON) and Social Services Director (SSD) and reported to them what Resident #26 had told her. Continued review of the investigation report revealed staff statements were obtained and two (2) staff interviewed, Licensed Practical Nurse (LPN) #12 and RN #4/ADON indicated SRNA #9 had reported concerns regarding the condition residents were left in by night shift staff on 07/03/14. Review of the written statement for LPN #12 revealed SRNA #9 reported to him her group of assigned residents, on the Southeast Hall of the South Unit, were all wet when she took over their care. LPN #12 noted in his written statement he told SRNA #9 to take it to RN #4/ADON or the DON, and the SRNA just turned and walked away. Review of RN #4's/ADON's written statement revealed SRNA #9 had stated late in the day on 07/03/14 that Resident #26 had reported to her he/she had been covered in feces up to his/her waist and no one had changed him/her. RN #4/ADON documented having spoken to SRNA #16 who had sat one on one with Resident #26, since around 6:20 AM. RN #4/ADON noted SRNA #16 told her SRNA #19 (the night shift SRNA) informed her she had not changed Resident #26 because the resident was a two (2) person assist, and she and the other night shift aide, SRNA #21 don't work together. However, continued review of the investigation report revealed no documented evidence SRNA #9 was interviewed by the facility regarding her concerns on 07/03/14. Interview with SRNA #9 on 07/03/14 at 2:44 PM, revealed she had never been interviewed regarding her concerns on 07/03/14, in regards to Resident #5, Resident #26, Resident #27, Resident #28 and Resident #29 being left wet and/or soiled by night shift staff. Even though she had expressed her concerns regarding the residents care to LPN #12 and RN #4/ADON which was documented on their written statements that was part of the investigation conducted 07/03/14 through 07/07/14. Interview, on 07/03/14 at 4:35 PM, with the RN #4/ADON revealed she had not talked directly to SRNA #9; however, indicated she should have. Per interview, RN #4/ADON stated she was not aware of a conflict between SRNA #19 and SRNA #21 at the time of the incident on 07/03/14. She stated if they were not working well together it could impact resident care. Additionally, review of the facility's investigation report dated 07/03/14 through 07/07/14, revealed staff interviews which indicated a conflict between SRNA #19 and SRNA #21, who were usually scheduled as the night shift SRNAs for the South Unit, on which all the aforementioned residents resided. Even though SRNA #19's phone interview statement revealed she had difficulty getting SRNA #21 to help her, and RN #4/ADON's written statement noted SRNA #19 and SRNA #21 didn't work together, there was no documented evidence

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) the facility interviewed the two (2) SRNAs about the conflict, or that the facility followed-up and addressed the issue to ensure residents were protected from possible further neglect. Interview conducted on 07/23/14 at 9:08 AM, with SRNA #19 revealed the DON had never discussed the incident involving Resident #26, on the morning of 07/03/14, with her. She stated she had never been asked to write a statement about what had occurred, and had never been interviewed by any of the administrative staff. However, review of the investigation report revealed a telephone interview was conducted with SRNA #19 on 07/03/14 by the Human Resources (HR) Director related to Resident #26. Continued interview with SRNA #19 revealed SRNA #21 and she had a conflict between them, and therefore did not work together when assigned as the two (2) SRNAs on the night shift for the South Unit. SRNA #19 stated she had told nurses about the conflict, and had written a grievance about the conflict and put it under the DON's office door. However, she stated nothing had ever been done and she had never been interviewed regarding the conflict. Interview, on 07/23/14 at 4:51 PM, with SRNA #21 revealed no one in the facility had ever discussed the incident involving 07/03/14 with her. Further review of the investigation report, dated 07/07/14, revealed Resident #26's concerns/allegation were unsubstantiated, as there were no findings of abuse or neglect. In addition, review of the investigation report revealed no documented evidence other non-interviewable residents also cared for by SRNA #19 on 07/03/14 had been assessed or their families/responsible parties interviewed. A group interview was held with the HR Director, Social Services Director (SSD) and DON on 07/23/14 at 5:49 PM. Per the SSD, she was responsible for abuse investigations. She stated on 07/03/14 the investigation performed had been focused on Resident #26's concerns. The SSD indicated she was unaware of a conflict between SRNA #19 and SRNA #21, even though two (2) staff reported concerns in staff interviews conducted on 07/03/14. The SSD reported the investigation report was reviewed by the former Administrator on 07/07/14, in conjunction with herself and the HR Director. Per the HR Director, she had assisted with the abuse investigation on 07/03/14 by interviewing the staff she thought had been assigned to Resident #26's care that day. She stated she was not sure why she had not interviewed SRNA #9. The HR Director stated she had investigated what she could; but had missed information in staff's statements, obtained during the investigation, including the conflict between SRNA #19 and SRNA #21, and SRNA #9's concerns about resident care. Per the DON, she had not reviewed the investigation after it was completed on 07/07/14, and she should have been more involved in the investigation as it was related to a nursing issue. The DON indicated she was unaware of SRNA #9's concerns reported by other staff in interview on 07/03/14. The DON stated the facility's investigation should have indicated why staff did not take action when SRNA #9 expressed concerns to them. Per interview, the DON indicated she was not sure if non-interviewable residents, cared for by SRNA #19, had been assessed. The DON stated she had not been aware of the conflict between SRNA #19 and SRNA #21 until 07/23/14, when RN #6 reported it to her. According to the DON, RN #6 told her, on 07/23/14, she had thought she could handle it; however, the DON stated RN #6 should have reported the conflict to Administration so it could be addressed. Interview, on 07/03/14 at 7:00 PM, with RN #6, the night shift nurse working with SRNA #19 on 07/03/14, revealed there was a personal conflict between SRNA #19 and SRNA #21, who were the SRNAs regularly scheduled on the unit. She stated due to the personal conflict between SRNA #19 and SRNA #21 resident care had been negatively impacted that night. RN #6 revealed she had not reported the information regarding the conflict between SRNA #19 and SRNA #21 to Administration; however, indicated she should have reported the incident. Continued interview with the SSD on 07/23/14 at 5:49 PM, revealed the former Administrator had determined the allegation to be unsubstantiated in regards to Resident #26's concerns from 07/03/14, as the facility hadn't been able to determine the timeframe for the resident having been left wet. However, review of the facility's investigation revealed documented evidence staff had expressed concerns regarding the condition residents had been found in the morning of 07/03/14, which included Resident #26 and Resident #29. Additional interview on 07/25/14 at 7:20 PM, with the HR Director and SSD revealed the SSD stated stated skin assessments should have been completed on all non-interviewable residents SRNA #19 had been responsible for from 11:00 PM on 07/02/14, through 7:00 AM on 07/03/14. Per interview, the SSD stated those residents' families or responsible parties should have been interviewed, and nursing staff would have needed to have been involved for residents who couldn't speak for themselves. Per interview, the HR Director revealed because the former Administrator had led and directed the investigation she and the SSD had not notified the DON of the results of the investigation. According to the HR Director, had she and the SSD known more detailed information like which residents were left wet she would have conducted a more thorough investigation. The HR Director stated she had been trained to investigate allegations by her Administrators in the past throughout the years. She stated she and the Administrators had gone through investigations, and she had performed interviews alongside the Administrators. Per interview, the HR Director stated she had a lot of hands on training, and had some formal training on investigating on hire. Interview, on 07/31/14 at 10:14 AM, with the former Administrator, who was in charge of the facility until 07/11/14, revealed she had became aware of a conflict between SRNA #19 and SRNA #21 through the DON during the investigation conducted on 07/03/14. She stated as Administrator she should have followed up on the conflict as it could impact resident care if the aides did not work together. She revealed she was not sure anyone addressed the two (2) SNRAs conflict; however, she stated the HR Director or Staff Development Nurse (SDN) should have addressed the conflict. However, interview with the SSD and DON revealed they were not aware of the conflict. The former Administrator stated the DON, the HR Director and SSD had performed the investigation. Per interview, she stated her part of the investigation had been to review it and come up with findings with the team. According to the former Administrator, she, the DON, the HR Director, and the SSD reviewed the investigation together, and determined the allegation to be unsubstantiated as they were unable to come up with a conclusion regarding how long Resident #26 had been left wet due to conflicting statements from staff. Continued interview revealed she, as the Administrator, did not read or review the investigation; the DON, HR and the SSD verbally talked about the investigation and it was determined the facility could not prove Resident #26 did not receive care. She stated SRNA #9 should have been interviewed regarding her concerns over resident care, if SRNA #9 had told staff about finding other residents wet. The former Administrator stated as part of a thorough investigation, skin assessments of non-interviewable residents should have been performed. Interview, on 07/25/14 at 8:09 PM, with the Special Projects Administrator for the corporation who owned the facility, revealed any time the facility learned of staff not working well together, it needed to be investigated and to see what was going on during that particular shift. The Special Projects Administrator stated skin assessments should have been performed on the non-interviewable residents, and their families called, as part of the investigation conducted on 07/03/14. However, he stated he had not been in the facility when the investigation had taken place, and had not reviewed the investigation report because he worked for the facility's corporation, and was the acting Administrator in another facility. He stated that when the former Administrator left on 07/11/14, the new Administrator took over. However, he stated the new Administrator was on vacation from 07/18/14 through 07/28/14, therefore he was there to cover for the new Administrator while on vacation. Interview, on 07/31/14 at 11:47 AM, with the current Administrator revealed he had started on 07/09/14, and had taken over as Administrator on 07/11/14. The current Administrator reported the former Administrator discussed with him an investigation which had been initiated on two (2) residents; however, he could not recall the residents. According to the current Administrator, typically investigations involved the HR Director, SSD, DON and himself; but indicated if it was a nursing issue it might just be the DON, SSD and himself involved. The current Administrator stated this process was in place before he came to work at the facility. However, interview revealed this process had not been implemented. Further interview with the current Administrator revealed he could not recall for certain if the former Administrator had informed him of the conflict between SRNA #19 and SRNA #21, but indicated he knew there had been issues with SRNA #19. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 that alleged removal of the IJ effective 07/29/14. Review of the AOC revealed the facility implemented the following: 1. The facility opened and investigated the five (5) reported allegations of neglect identified on the 06/30/14 through 07/03/14 Survey for Residents #5, #26, #27, #28, and #29. Initial Reports were completed with the five (5) day follow up reports pending completion of the investigations. The allegations were investigated by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant. 2. One hundred percent (100%) of the resident population received head to toe assessments by the DON, the ADON, MDS Coordinator, Wound Care Nurse, SDC, Evening Nurse Supervisor, Corporate Nurse Consultant and Charge Nurses on 07/23/14. 3. Residents with a BIMS of eight (8) or above were interviewed by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Supply Coordinator, Quality of Life Director or Chaplain which was completed on 07/25/14 for any abuse, neglect, or misappropriation concerns. 4. Families and responsible parties were interviewed for residents with a BIMS below eight (8) which was initiated on 07/25/14 and as of 07/28/14, thirty-seven (37) of fifty-six (56) had been completed, for any abuse, neglect, or misappropriation concerns. The facility would continue to attempt contacting families and responsible parties daily to identify any concerns until

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) remaining Power of Attorney's (POA's) had been reached. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. 5. Staff was interviewed for any abuse, neglect, or misappropriation concerns by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Quality of Life Director or Chaplain on 07/25/14. Initial reports were made on the allegations relative to those interviews. 6. Initial Reports were made on 07/25/14 related to the alleged allegations relative to the interviews with residents, families, responsible parties, and staff. Thorough investigations were initiated on 07/25/14 by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant on those residents identified with appropriate follow up reporting on the allegations received. 7. Abuse, neglect and misappropriation audits, assessments, interviews and questionnaires were reviewed by the Special Projects Administrator, DON, Corporate Nurse Consultant or Chief Nurse Executive on 07/27-07/28/14 for any indications of abuse, neglect or misappropriation concerns. 8. The Medical Director was notified of the Immediate Jeopardy on 07/25/14 by the DON and Special Projects Administrator. An Emergency Quality Assurance (QA) Meeting was held on 07/26/14 with the Corporate Director of Risk Management, Clinical Nurse Executive, Corporate Nurse Consultant, Medical Director, Special Projects Administrator, DON, HR Director, SSD and SDC related to the Immediate Jeopardy. 9. The DON, two (2) ADONs, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions, Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse were re-educated on 07/23/14 and the Administrator was re-educated on 07/28/14, upon his return, by the Corporate Nurse Consultant on the Abuse, Neglect and Misappropriation Policy and Procedure which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans. They could not return to work until the abuse, neglect, misappropriation education was provided and post test administered and a one hundred percent (100%) score was obtained on the post test. If a manager did not score a one hundred percent (100%) on post test, the manager was immediately re-educated and a post test was re-administered. 10. The facility's Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse educated stakeholders related to the Abuse, Neglect, and Misappropriation Policy which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans starting on 07/23/14 and continued until 07/28/14. No staff would be allowed to work until this education was provided and the post test administered and a one hundred percent (100%) score obtained. Eighty-seven (87) of ninety-six (96) were completed by 07/28/14. 11. Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse provided education to stakeholders which was initiated on 07/26/14 to nursing staff related to incontinence care and Activities of Daily Living (ADL's) care per the Care Plan and answering call lights. Calls and certified letters had been sent notifying staff they must complete training before returning to work relative to incontinence care and Activities of Daily Living (ADL's) Care per resident individualized Care Plan and answering call lights in a timely manner. 12. Education regarding the Abuse, Neglect and Misappropriation Policy would be included in the orientation process for newly hired staff. No newly hired person would be able to work until this education was provided and a post test administered and one hundred percent (100%) score obtained provided by staff development. 13. Staff assessment of knowledge test regarding abuse, neglect and misappropriation was being administered by the Administrator, DON, ADON's, MDS Coordinator, SDC, Dietary Director, Medical Records Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse to five (5) staff members on each shift and different staff members until the immediacy was removed. 14. Ten (10) staff questionnaires would be administered daily to ensure continued understanding of the Abuse, Neglect and Misappropriation Policy. Results of the questionnaires, tests, ten (10) resident skin assessments of residents with a BIMS less than eight (8) per day, ten (10) residents with a BIMS greater than eight (8) interviews would be reviewed daily until the immediacy was resolved by the Administrator, DON, Nurse Consultant or Chief Nurse Executive. Any concerns revealed on the above to include injuries of unknown source would be reported immediately to the Abuse Coordinator, Administrator, DON, Corporate Nurse Coordinator, Regional Vice President of Operations, Special Projects Administrator, or Chief Nurse Executive. 15. Results of the staff questionnaires, resident interviews and skin assessments would be reviewed daily by the Administrator, DON, Nurse Consultant or Chief Nurse Executive with results reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of plan. Based on the evaluation the QA Committee would decide at what frequency the staff questionnaire would need to continue. Concerns identified would be corrected immediately and reported to the Administrator or DON to ensure an investigation of suspected abuse, neglect or misappropriation was investigated/completed and reporting guidelines were met along with any reporting of violation of resident rights. 16. Administrator, DON, ADONs, MDS Coordinator, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Director, Plant Operations Director, Quality of Life Director, Wound Care Nurse, Corporate Nurse Consultant, Regional Vice President or Clinical Nurse Executive would conduct call light audits through direct observation and monitoring tool daily twenty-four (24) hours a day seven (7) days a week on each shift to monitor compliance until the immediacy was removed. Then five (5) call lights daily on each shift (fifteen (15) total) ongoing and reported to QA Committee weekly during immediacy and monthly after immediacy was removed. Charge Nurses would provide direct observation of call light responsiveness and ensure all residents were getting needs met for plan of care each shift. Incontinence care observation would be completed for ten (10) residents daily until the immediacy was removed then ongoing for five (5) residents daily with results being reported to the QA Committee weekly during immediacy and monthly after the immediacy was removed. 17. Human Resources (HR) Director performed an audit of staff files for any abuse, neglect or misappropriation concerns 7/26/14 through 7/27/14 and the items reviewed included coaching, counseling forms, suspension forms, termination forms, abuse registry checks, background checks and licensure to 07/03/14. Results of the audit was given to the Administrator, DON or Corporate Nurse Consultant on 07/27/14, to review for any abuse, neglect or misappropriation concerns that needed reported. None were identified. 18. Information on Caring for the Caregiver which addresses the signs of stress and burn out, showing the caregiver ways to cope and reduce stress and useful ways that friends could offer help to the caregiver were posted by the time clock on 07/27/14 by the Special Projects Administrator. 19. A nurse from the regional team or corporate office had been onsite since 07/21/14 and would remain in the facility daily until the Immediate Jeopardy was lifted. The nurses from the regional team home office were assisting with investigations, observing staff treatment of [REDACTED]. The Chief Nurse Executive would be in daily contact with the Corporate Nurse Consultant and would review allegations. 20. Grievances and Resident Questionnaires since 07/23/14 were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director or Regional Nurse Consultants 07/27/14 through 07/28/14 to determine if any items documented were a reportable event. All issues identified were reported and investigations initiated per the facility's policy and procedure. The Administrator, SSD, or the DON would review daily, the grievances and Incident/Accident Reports, until immediacy was lifted, starting 07/27/14 to determine if there were reportable allegations which had been identified, then daily Monday through Friday during the Morning Stand-Up Meeting. SSD or the DON would report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator would review any allegations of abuse, neglect or misappropriation for reporting to the Office of Inspector General, Adult Protective Services and Ombudsman and appropriate authorities as required by state law. 21. The Administrator, DON, SSD would review and discuss abuse, neglect and misappropriation allegations daily to ensure the resident was protected, the perpetrator was removed from resident care area, reports to the State Survey Agency, APS and Ombudsman were filed timely, and a thorough investigation was completed. The Abuse Coordinator (SSD) would maintain an abuse, neglect and misappropriation investigation log starting on 07/27/14 that would include documentation of the following: validate protection of residents; perpetrator was removed from resident care area; reports to the State Survey Agency and Adult Protective Services (APS) were filed timely; and a thorough investigation was completed. The Abuse Coordinator and one of the following: Administrator, DON, Chief Nurse Executive or Regional Nurse Consultant would review the abuse, neglect and misappropriation log daily until removal of the Immediate Jeopardy, beginning on 07/27/14, to validate protection of the resident, that the

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) perpetrator was removed from the resident care area, that reports to the State Survey Agency and APS and appropriate authorities required by state law, were filed timely, and a thorough investigation had been completed. 22. In the event of any new reports of alleged abuse, neglect, or misappropriation of
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on interview, record review, review of the facility's investigation reports and policy, during the 08/01/14 survey, it was determined the facility failed to have an effective system in place to ensure the facility's policies and procedures related to abuse/neglect were implemented for five (5) of thirty-seven (37) sampled residents (Residents #5, #26, #27, #28, #29). On 07/03/14, at approximately 5:30 AM, Resident #26 rang his/her call light to request assistance, from the night shift staff, to be cleaned after being incontinent. However, Resident #26 did not receive the requested assistance until approximately 7:45 AM, when the day shift State Registered Nursing Assistants (SRNAs) assisted the resident. Interviews with the day shift SRNAs revealed Resident #26 was covered in bowel movement (BM) and urine soaked when they assisted the resident. Interviews with the day shift staff revealed other residents were also left urine soaked or soiled with BM that same morning, 07/03/14. The other residents included Resident #5, Resident #27, Resident #28 and Resident #29. (Refer to F-224, F-225) Additionally, during the facility's investigation a conflict was identified between the two (2) night shift SRNAs usually assigned to care for the residents involved, who did not work together when providing care for residents. However, the facility failed to address the conflict between the SRNAs which impacted resident care on night shift on the South Unit, where the residents all resided, leaving residents at risk for further neglect. In addition, review of the facility's policy and procedure related to abuse and neglect revealed the policy did not clearly state all allegations of abuse would be investigated per the regulation, F-225. The facility's failure to have an effective system in place to ensure the implementation of abuse policies and procedures to prevent neglect was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 07/25/14, and determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14, with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure an effective system is in place to ensure abuse policies and procedures are implemented to prevent neglect of residents. The findings include: Review of the facility's policy titled, Abuse, Neglect and Misappropriation, dated April 2013 revealed the facility prohibited abuse or neglect of residents. Review of the Policy revealed staff was to be trained on abuse to include what constituted abuse, neglect or misappropriation of resident property. The Policy revealed all allegations of abuse were to be investigated, and the Administrator/designee was to make all reasonable efforts to investigate and address alleged reports, grievances and concerns. Further review revealed Social Services or the Chaplain were to follow up with the resident to monitor his/her emotional well-being after an incident, and families were to be notified of the outcome of the investigation. Post-survey interview with the current Administrator, on 08/12/14 at 4:40 PM, revealed where the facility's abuse policy stated the Administrator/designee was to make reasonable effort to investigate and address allegations of abuse or neglect meant doing whatever it took to find out the circumstances of an incident. He stated all investigations were to be investigated and reported, and all efforts made to address all investigations, allegations, concerns or grievances. However, he indicated the policy wording was confusing, and indicated the wording in the policy needed to be changed to clearly state all allegations of abuse would be investigated as per the regulation. Review of the facility's investigation report forms dated 07/03/14, and documented as concluded on 07/07/14, revealed Resident #26 had voiced concerns related to possible failure by a night shift SRNA to provide care. Review of the staff's written statements and interviews revealed staff interviewed during the investigation reported Resident #5, Resident #27, Resident #28 and Resident #29 had also been left wet and/or soiled the morning of 07/03/14. However, continued review of the statements and staff interviews revealed no documented evidence Resident #5, Resident #27, Resident #28 and Resident #29 were assessed or staff concerns were investigated or followed-up on related to these residents as per facility policy. Additional review of the staff interviews and written statements in the investigation report revealed two (2) staff had reported SRNA #9 had voiced concerns regarding resident care issues on 07/03/14, and staff also, indicated there was a conflict between SRNA #19 and SRNA #21 who worked on night shift. However, there was no documented evidence SRNA #9 was interviewed regarding her concerns and no documented evidence the facility had addressed the conflict reported between SRNA #19 and SRNA #21 to ensure an investigation was conducted to prevent neglect as per facility policy. Interview on 07/23/14 at 5:49 PM, with the Human Resources (HR) Director, Social Services Director (SSD) and Director of Nursing (DON) revealed the investigation conducted on 07/03/14 had been focused on Resident #26's concerns. The HR Director stated she interviewed the staff she thought had been assigned to the residents the morning of 07/03/14; however, she was not sure why SRNA #9 was not interviewed. Further interview revealed even though she had assisted with the investigation performed 07/03/14 through 07/07/14 where staff interviewed indicated a conflict between SRNA #19 and SRNA #21, she was not aware of a conflict between the two (2) SRNAs. The HR Director stated she had missed the information in staff's statements she obtained on 07/03/14, such as, SRNA #9's concerns reported to two (2) staff regarding resident care, and the conflict between SRNA #19 and SRNA #21. In interview, the DON stated after completion of the investigation on 07/07/14, she had not reviewed the investigation report. According to the DON, she was not aware of SRNA #9's concerns reported during the investigation; however, she stated the investigation should have noted why the staff had not taken action, when the SRNA expressed concerns regarding resident care to staff. However, interview, on 07/31/14 at 10:14 AM, with the former Administrator, who was in charge of the facility until 07/11/14, revealed the DON did make her aware of the conflict between SRNA #19 and SRNA #21. However, she failed to follow-up on it during the investigation conducted on 07/03/14. She stated the conflict could have impacted resident care if the SRNAs did not work together. She further revealed the HR Director or Staff Development Nurse (SDN) should have addressed the conflict, as per facility policy. The former Administrator stated the DON, the HR Director and SSD had performed the investigation, and her part of the investigation had been to review it and come up with findings; however, the investigation information was verbally reported to her and she had not read the investigation report. The former Administrator indicated as Administrator she should have ensured a thorough investigation was performed to include: interviewing SRNA #9's regarding her concerns of residents left wet and/or soiled on 07/03/14; ensuring those residents were assessed; ensuring the interviewable residents concerns were investigated; and ensuring the conflict between SRNA #19 and SRNA #21 was investigated and addressed as per the policy. Interview, on 07/31/14 at 11:47 AM, with the current Administrator revealed he had taken over as Administrator on 07/11/14, and indicated he was aware of the facility's abuse policy, he had been involved in investigations, and was aware of the status of investigations. He stated as Administrator he read the final investigation reports, and findings were also verbally reported to him by staff involved in the investigations. The current Administrator stated this process was in place prior to his taking over as Administrator of the facility. However, interview and record review revealed the process/procedure had not been implemented. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 that alleged removal of the IJ effective 07/29/14. Review of the AOC revealed the facility implemented the following: 1. The facility opened and investigated the five (5) reported allegations of neglect identified on the 06/30/14 through 07/03/14 Survey for Residents #5, #26, #27, #28, and #29. Initial Reports were completed with the five (5) day follow up reports pending completion of the investigations. The allegations were investigated by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant. 2. One hundred percent (100%) of the resident population received head to toe assessments by the DON, the ADON, MDS Coordinator, Wound Care Nurse, SDC, Evening Nurse Supervisor, Corporate Nurse

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) Consultant and Charge Nurses on 07/23/14. 3. Residents with a BIMS of eight (8) or above were interviewed by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Supply Coordinator, Quality of Life Director or Chaplain which was completed on 07/25/14 for any abuse, neglect, or misappropriation concerns. 4. Families and responsible parties were interviewed for residents with a BIMS below eight (8) which was initiated on 07/25/14 and as of 07/28/14, thirty-seven (37) of fifty-six (56) had been completed, for any abuse, neglect, or misappropriation concerns. The facility would continue to attempt contacting families and responsible parties daily to identify any concerns until remaining Power of Attorney's (POA's) had been reached. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. 5. Staff was interviewed for any abuse, neglect, or misappropriation concerns by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Quality of Life Director or Chaplain on 07/25/14. Initial reports were made on the allegations relative to those interviews. 6. Initial Reports were made on 07/25/14 related to the alleged allegations relative to the interviews with residents, families, responsible parties, and staff. Thorough investigations were initiated on 07/25/14 by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant on those residents identified with appropriate follow up reporting on the allegations received. 7. Abuse, neglect and misappropriation audits, assessments, interviews and questionnaires were reviewed by the Special Projects Administrator, DON, Corporate Nurse Consultant or Chief Nurse Executive on 07/27-07/28/14 for any indications of abuse, neglect or misappropriation concerns. 8. The Medical Director was notified of the Immediate Jeopardy on 07/25/14 by the DON and Special Projects Administrator. An Emergency Quality Assurance (QA) Meeting was held on 07/26/14 with the Corporate Director of Risk Management, Clinical Nurse Executive, Corporate Nurse Consultant, Medical Director, Special Projects Administrator, DON, HR Director, SSD and SDC related to the Immediate Jeopardy. 9. The DON, two (2) ADONs, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions, Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse were re-educated on 07/23/14 and the Administrator was re-educated on 07/28/14, upon his return, by the Corporate Nurse Consultant on the Abuse, Neglect and Misappropriation Policy and Procedure which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans. They could not return to work until the abuse, neglect, misappropriation education was provided and post test administered and a one hundred percent (100%) score was obtained on the post test. If a manager did not score a one hundred percent (100%) on post test, the manager was immediately re-educated and a post test was re-administered. 10. The facility's Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse educated stakeholders related to the Abuse, Neglect, and Misappropriation Policy which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans starting on 07/23/14 and continued until 07/28/14. No staff would be allowed to work until this education was provided and the post test administered and a one hundred percent (100%) score obtained. Eighty-seven (87) of ninety-six (96) were completed by 07/28/14. 11. Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse provided education to stakeholders which was initiated on 07/26/14 to nursing staff related to incontinence care and Activities of Daily Living (ADL's) care per the Care Plan and answering call lights. Calls and certified letters had been sent notifying staff they must complete training before returning to work relative to incontinence care and Activities of Daily Living (ADL's) Care per resident individualized Care Plan and answering call lights in a timely manner. 12. Education regarding the Abuse, Neglect and Misappropriation Policy would be included in the orientation process for newly hired staff. No newly hired person would be able to work until this education was provided and a post test administered and one hundred percent (100%) score obtained provided by staff development. 13. Staff assessment of knowledge test regarding abuse, neglect and misappropriation was being administered by the Administrator, DON, ADON's, MDS Coordinator, SDC, Dietary Director, Medical Records Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse to five (5) staff members on each shift and different staff members until the immediacy was removed. 14. Ten (10) staff questionnaires would be administered daily to ensure continued understanding of the Abuse, Neglect and Misappropriation Policy. Results of the questionnaires, tests, ten (10) resident skin assessments of residents with a BIMS less than eight (8) per day, ten (10) residents with a BIMS greater than eight (8) interviews would be reviewed daily until the immediacy was resolved by the Administrator, DON, Nurse Consultant or Chief Nurse Executive. Any concerns revealed on the above to include injuries of unknown source would be reported immediately to the Abuse Coordinator, Administrator, DON, Corporate Nurse Coordinator, Regional Vice President of Operations, Special Projects Administrator, or Chief Nurse Executive. 15. Results of the staff questionnaires, resident interviews and skin assessments would be reviewed daily by the Administrator, DON, Nurse Consultant or Chief Nurse Executive with results reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of plan. Based on the evaluation the QA Committee would decide at what frequency the staff questionnaire would need to continue. Concerns identified would be corrected immediately and reported to the Administrator or DON to ensure an investigation of suspected abuse, neglect or misappropriation was investigated/completed and reporting guidelines were met along with any reporting of violation of resident rights. 16. Administrator, DON, ADONs, MDS Coordinator, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Director, Plant Operations Director, Quality of Life Director, Wound Care Nurse, Corporate Nurse Consultant, Regional Vice President or Clinical Nurse Executive would conduct call light audits through direct observation and monitoring tool daily twenty-four (24) hours a day seven (7) days a week on each shift to monitor compliance until the immediacy was removed. Then five (5) call lights daily on each shift (fifteen (15) total) ongoing and reported to QA Committee weekly during immediacy and monthly after immediacy was removed. Charge Nurses would provide direct observation of call light responsiveness and ensure all residents were getting needs met for plan of care each shift. Incontinence care observation would be completed for ten (10) residents daily until the immediacy was removed then ongoing for five (5) residents daily with results being reported to the QA Committee weekly during immediacy and monthly after the immediacy was removed. 17. Human Resources (HR) Director performed an audit of staff files for any abuse, neglect or misappropriation concerns 7/26/14 through 7/27/14 and the items reviewed included coaching, counseling forms, suspension forms, termination forms, abuse registry checks, background checks and licensure to 07/03/14. Results of the audit was given to the Administrator, DON or Corporate Nurse Consultant on 07/27/14, to review for any abuse, neglect or misappropriation concerns that needed reported. None were identified. 18. Information on Caring for the Caregiver which addresses the signs of stress and burn out, showing the caregiver ways to cope and reduce stress and useful ways that friends could offer help to the caregiver were posted by the time clock on 07/27/14 by the Special Projects Administrator. 19. A nurse from the regional team or corporate office had been onsite since 07/21/14 and would remain in the facility daily until the Immediate Jeopardy was lifted. The nurses from the regional team home office were assisting with investigations, observing staff treatment of [REDACTED]. The Chief Nurse Executive would be in daily contact with the Corporate Nurse Consultant and would review allegations. 20. Grievances and Resident Questionnaires since 07/23/14 were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director or Regional Nurse Consultants 07/27/14 through 07/28/14 to determine if any items documented were a reportable event. All issues identified were reported and investigations initiated per the facility's policy and procedure. The Administrator, SSD, or the DON would review daily, the grievances and Incident/Accident Reports, until immediacy was lifted, starting 07/27/14 to determine if there were reportable allegations which had been identified, then daily Monday through Friday during the Morning Stand-Up Meeting. SSD or the DON would report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator would review any allegations of abuse, neglect or misappropriation for reporting to the Office of Inspector General, Adult Protective Services and Ombudsman and appropriate authorities as required by state law. 21. The Administrator, DON, SSD would review and discuss abuse, neglect and misappropriation allegations daily to ensure the resident was protected, the perpetrator was removed from resident care area, reports to the State Survey Agency, APS and

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) Ombudsman were filed timely, and a thorough investigation was completed. The Abuse Coordinator (SSD) would maintain an abuse, neglect and misappropriation investigation log starting on 07/27/14 that would include documentation of the following: validate protection of residents; perpetrator was removed from resident care area; reports to the State Survey Agency and Adult Protective Services (APS) were filed timely; and a thorough investigation was completed. The Abuse Coordinator and one of the following: Administrator, DON, Chief Nurse Executive or Regional Nurse Consultant would review the abuse, neglect and misappropriation log daily until removal of the Immediate Jeopardy, beginning on 07/27/14, to validate protection of the resident, that the perpetrator was removed from the resident care area, that reports to the State Survey Agency and APS and appropriate authorities required by state law, were filed timely, and a thorough investigation had been completed. 22. In the event of any new reports of alleged abuse, neglect, or misappropriation of property, after the Immediate Jeopardy was removed, the Signature Care Consultant or Chief Nursing Executive would validate the resident was protected, report was filed timely, the perpetrator was removed from resident care area and a thorough investigation was completed. 23. Beginning on 07/27/14, the care plan conferences for each resident would include any abuse, neglect or misappropriation concerns which the residents or families had. Resident safety would be validated and then the allegation would be reported to the Charge Nurse. The Abuse,Neglect and Misappropriation Policy would then be followed. 24. Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, Chief Nursing Officer, Signature Care Consultant, member of the regional staff team or Chief Operating Officer daily until removal of the immediacy beginning 07/21/14, then weekly for four (4) weeks, then monthly. 25. A Quality Assurance Meeting would be held weekly for four (4) weeks beginning 07/26/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee would determine at what frequency any ongoing audits would need to continue. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facilities investigations revealed the five (5) reported allegations involving Resident's #5, #27, #28, and #29 have been completed with a five (5) day follow up. A re-investigation was done related to allegations for Resident #26. Interview, on 07/31/14 at 7:08 PM, with the Corporate Nurse Consultant revealed the facility had investigated the allegations regarding Resident's #5, #26, #27, #28, and #29 and found them all to be substantiated. 2. Review of copies of resident head to toe assessments revealed all residents were assessed and the assessments were performed on 07/23/14 on North and South Hall, with a recorded census on 07/23/14 of fifty six (56) residents on North Hall and fifty-one (51) residents on South Hall. There was no concerns revealed during review of the skin assessments. Interview, on 07/31/14 at 5:26 PM, with the Wound Care Nurse revealed she was in charge of the skin assessments, and she and other nurses completed skin assessments on one hundred percent (100%) of the residents in the building. 3. Review of Resident Interviews revealed residents with a BIMS of eight (8) and above were interviewed, which included forty-six (46) residents, related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. 4. Review of family interviews for residents with a BIMS of less than eight (8) revealed thirty-seven (37) of fifty-six (56) of these interviews were completed as of 7/28/14 related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. Interview with the DON on 08/01/14 at 10:00 AM, revealed the interviewable residents were interviewed, as well as, the families of residents with a BIMS score of less than eight (8) and she reviewed the interviews for any concerns. 5. Review of the Stakeholder (Staff) Investigative Interviews revealed they were conducted in reference to abuse, neglect and misappropriation concerns 7/23/14 through 7/25/14 for all regular and part-time staff. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all interviewed and asked if they were aware of any abuse, neglect, or misappropriation. 6. Review of the allegations relative to the interviews with residents, families, responsible parties, and staff concerns revealed they were investigated with initial reports completed. Interview with the Corporate Nurse Consultant on 07/31/14 at 7:08 PM revealed there was several reportable allegations from the interviews which she assisted with conducting, and the facility investigated with follow up actions and reporting. 7. Review of the Abuse, Neglect, and Misappropriation audits, assessments, interviews and questionnaires revealed they were reviewed by the DON, Corporate Nurse Consultant, Chief Nurse Executive or Special Projects Administrator on 07/27/14 and 07/28/14. Interview with the DON on 08/01/14 at 10:00 AM revealed they expanded on the abuse questions giving scenarios to the staff to have them choose which type of abuse was occurring in the scenarios. She stated she reviewed the abuse audits, assessments, interviews, and questionnaires. 8. Review of the Quality Assurance Signature Sheet and Minutes revealed an Emergency QA meeting was held on Saturday, 07/26/14, with the Medical Director, Special Projects Administrator, Director of Nursing Services, Director of Clinical Risk Management, Staff Development, Certified Nurse Executive, Corporate Nurse Consultant, Human Resources Director, and Social Services Director to discuss current Immediate Jeopardy deficiencies and a Plan of Correction. Interview with the DON on 08/01/14 and the Corporate Nurse Consultant on 07/31/14 at 7:08 PM confirmed the QA Meeting was held on 07/26/14 with the Medical Director. Interview with the HR Director on 07/31/14 at 5:45 PM revealed during the emergency QA Meeting they discussed the Immediate Jeopardy deficiencies and the reason for the deficiencies as well as discussed the audits, interviews, questionnaires and interviewing that was being done related to the deficiencies. 9. Review of the sign in sheets dated 07/23/14 regarding training for the Administrative staff of the facility regarding the Abuse, Neglect and Misappropriation Policy revealed the Certified Nurse Executive educated the DON, ADON's, MDS Coordinator, SDC, Dietary Director, Business Office Manager, Social Services Director, Chaplain, Admissions Director, Medical Records, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director , Quality of Life Director and Wound Care Nurse received the training. Review of the sign in sheet on 07/28/14 for training on the Abuse, Neglect and Misappropriation Policy, revealed the Administrator of the facility was educated on skin assessments, interviews, the Abuse, Neglect, and Misappropriation Policy, and the Education session regarding the Plan of Correction. Interview with the ADON/UM of the South Unit on 07/31/14 at 3:30 PM, ADON/UM of the North Unit on 07/31/14 at 4:45 PM, HR Director on 07/31/14 at 5:45 PM, the Dietary Director on 07/31/14 at 6:15 PM, and the DON on 08/01/14 at 10:00 AM, revealed they received training on abuse, neglect and misappropriation and had to take a post test in which they had to score a one hundred percent (100%). Review of the POS [REDACTED]. Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant, revealed the Department Administrative Managers scored a one hundred percent (100%) on the post test related to abuse, neglect and misappropriation education. 10. Review of the inservices revealed education was conducted with stakeholders related to abuse, neglect, and misappropriation 07/23/14 through 07/28/14 in which they had to score a one hundred percent (100%) on the post test or retake the test. Interview with the Staff Development Coordinator (SDC) on 07/31/14 at 5:15 PM, and the SSD on 07/31/14 at 6:30 PM revealed she and other administrative staff educated the stakeholders related to abuse, neglect and misappropriation and completed these inservices. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated on the facility's Abuse, Neglect and Misappropriation Policy, which included training, prevention, identification, investigation, protection and reporting. Review of the sign in sheets from 07/23/14 through 07/28/14 revealed inservices were conducted with the facility staff regarding the Abuse and Neglect Policy. Review of the POS [REDACTED]. Documentation provided from the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:

F 0276 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Check and assess each resident's assessment at least every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facility policy, it was determined the facility failed to ensure Minimum

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F 0276 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) Data Set (MDS) Assessments were completed within three (3) months of the most recent clinical assessment for one (1) of thirty-seven (37) sampled residents (Resident #28). The facility completed a Quarterly MDS Assessment with an Assessment Reference Date (ARD) of 03/26/14; however, they failed to complete a subsequent MDS Assessment within ninety-two (92) days as required. The findings include: Review of the Resident Assessment Instrument (RAI) User Manual Version 3.0, Chapter (2), Section (5), revealed the ARD must be within ninety-two (92) days after the ARD of the previous Assessment. Review of Resident #28's medical record revealed the resident had [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment with an ARD date of 03/26/14, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) score of seven (7), which indicated the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for bed mobility, transfers, and locomotion on and off the unit. Continued review of the MDS revealed the facility assessed the resident as requiring limited assist of one (1) staff for the following: ambulation in the room, dressing, eating, toilet use, personal hygiene and bathing. Further review revealed there was no documented evidence of subsequent MDS Assessments for review. Interview, on 07/26/14 at 1:35 PM, with Registered Nurse (RN) #1 who was the MDS Coordinator for the South Unit, revealed she had started in the position on 06/28/14. She stated she was under the impression the MDS Assessment which were due to be completed in June 2014 were already completed by Licensed Practical Nurse (LPN) #1, (the previous MDS Coordinator for the South Unit). She stated she was informed by LPN #1 who had also given her a calendar with the MDS Assessments listed which were due for July 2014 when she started the position. Continued interview revealed there must have been a miscommunication between LPN #1 and herself due to the change in positions. Further interview revealed she needed to complete a Significant Change MDS for Resident #28 and she did not realize it was due until she was informed by the Surveyor the previous day, 07/25/14. She stated the first time she had noticed the MDS Assessments, which were due to be completed in June 2014, were late was last week. Interview, on 07/26/14 at 2:00 PM, with LPN #1 revealed she had been the MDS Coordinator for the South Unit until 07/03/14. She stated there was a schedule of MDS Assessments which were due and she had opened the MDS Assessments which were to be done for June 2014. She further stated she had given RN #10 the list of MDS Assessments due in June 2014, and told her the Assessments had been opened in order for her to finish them. She stated the MDS ARD for Resident #28 was 06/26/14 and the MDS Assessment would be late fourteen (14) days past 06/26/14.
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Minimum Data Set (MDS) Manual and review of the facility's policy, it was determined the facility failed to ensure the MDS Assessment was accurate for two (2) of thirty-seven (37) sampled residents (Residents #11 and #13). Resident #11 experienced a Urinary Tract Infection [MEDICAL CONDITION] during the assessment period; however, the UTI was not coded on the MDS Assessment. Additionally, Resident #13's weight was coded incorrectly on the most recent MDS Assessment. The findings include: Review of the MDS Manual, dated October 2011, revealed Item I2300 Urinary Tract Infection [MEDICAL CONDITION] had a look-back period of thirty (30) days for active disease instead of seven (7) days. Staff was to code only if all the following were met: the Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist or other authorized licensed staff as permitted by state law diagnosed a UTI in the last thirty (30) days. 1. Review of Resident #11's medical record revealed the facility admitted the resident on 06/27/13, with [DIAGNOSES REDACTED]. Review of Resident #11's Quarterly MDS, dated [DATE], revealed the facility assessed the resident as being severely impaired. Continued record review revealed a Nurse's Note, dated 11/15/13, which stated Resident #11 had been found on the floor and was alert with some confusion. Review of the Physician's Telephone Order, dated 11/18/13, revealed an order to obtain a Urine Analysis (UA) with Culture and Sensitivity for Resident #11. Record review revealed Resident #11's urine was obtained and sent to the laboratory (lab). The lab's final report dated 11/21/13, revealed Resident #11 was noted to have Escherichia Coli (E-coli) in his/her urine. Record review revealed the Physician was notified on 11/21/13, and ordered [MEDICATION NAME] (an antibiotic) 100 milligrams (mgs) by mouth every twelve (12) hours for seven (7) days. However, review of Resident #11's Annual MDS, dated [DATE], revealed Section I, was not coded for the resident having had a UTI in the last thirty (30) days. Interview, on 07/02/14 at 4:38 PM, with MDS Coordinator #3, for the North Unit, revealed the MDS Coordinators were responsible for coding the MDS Assessments correctly. MDS Coordinator #3 reviewed Resident #11's medical record, and stated if the resident had been diagnosed with [REDACTED]. She stated as Resident #11 was diagnosed with [REDACTED]. 2. Review of the MDS Manual, dated October 2011, revealed Item K0200, Height and Weight had a look-back period of thirty (30) days for the items. Staff was to check the medical record for weights and enter the weight taken within the last thirty (30) days. Continued review revealed if a resident's weight was taken more than once during the preceding month, staff should enter the most current weight. Review of Resident #13's record revealed the facility admitted the resident on 06/27/13, with [DIAGNOSES REDACTED]. Review of Resident #13's Annual MDS, dated [DATE], revealed under Section K, the resident was coded to have a weight of one hundred and ninety-four (194) pounds, with no weight loss or weight gain. Resident #13 was assessed to be moderately cognitively impaired. Observation of Resident #13, on 07/02/14 at 3:24 PM, revealed Resident #13 was observed to be physically obese, lying on the bed with the television on. Review of Resident #13's medical record revealed the resident was coded on the Quarterly MDS, dated [DATE], under Section K to have a weight of only fourteen (14) pounds with no weight loss or gain. Interview with MDS Coordinator #7, for the South Unit, on 07/03/14 at 5:16 PM, revealed Resident #13's weight was coded incorrectly on his/her Quarterly MDS Assessment, dated 04/11/14. She reported the resident's weight should have been documented as one hundred and ninety-four (194) pounds on the Quarterly MDS Assessment. Interview with the Director of Nursing (DON), on 07/03/14 at 5:20 PM, revealed it was her expectation for MDS staff to code residents' MDS Assessment correctly. The DON stated if an MDS was not correct, then staff should compete a modification of the MDS.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the Resident Assessment Instrument (RAI) Manual 3.0 Version, and review of facility's policy, it was determined the facility failed to develop a Comprehensive Plan of Care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for six (6) of thirty-seven (37) sampled residents (Residents #14, #16, #24, #26, #30, and #31). Resident #14's Comprehensive Care Plan was not developed related to communication and [MEDICAL CONDITION] medications, although the Minimum Data Set (MDS) Care Area Assessments (CAAs) triggered for those areas. In addition, review of the Comprehensive Plans of Care for Resident #16, #24, #26, #30 and #31 revealed the Care Plans were not developed to include specific interventions related to how many staff was required and/or how often the resident was to be toileted; receive incontinence care; be turned and repositioned; or, be transferred in order for staff to provide the care indicated as required on the Comprehensive Assessment. The findings include: Review of the facility's policy titled, Care Planning-Interdisciplinary Team (IDT), revised 10/13, revealed the care plan was based on the resident's comprehensive assessment and was developed by the IDT and should include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. The Interdisciplinary Process included identifying problem areas and their causes, and developing interventions that were targeted and meaningful to the resident. Review of the Resident Assessment Instrument Version 3.0 Manual (section 4.1) revealed the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Further review of the Manual (section 4.4) revealed facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs. The process focuses on evaluating these triggered care areas using the (Care Area Assessments) CAAs, but does not provide exact detail on how to select pertinent intervention for care planning. Interventions must be individualized and based on applying effective problem solving and decision making approaches to all of the information available for each resident. Section 4.7 states in selecting interventions and planning care, the key task would be to identify specific symptomatic and cause specific interventions for physical, functional, and psychosocial needs. Interview

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) with Licensed Practical Nurse (LPN) #1, on 07/27/14 at 11:05 AM, revealed she was the Minimum Data Set (MDS) Coordinator, who was in charge of completing the MDSs and developing the Care Plans on the South Unit until 07/03/14. She stated the care plans were generated from the computer and then reviewed to ensure interventions were appropriate which needed to be modified by software or handwritten. LPN #1 further stated the Care Plan did not have to specifically state how many staff were required to assist with ADLs or how often the assistance was needed because this was specified in the State Registered Nursing Assistant (SRNA) Care Plan Record which was a part of the permanent record. 1. Review of Resident #14's medical record revealed the facility admitted the resident on 03/25/14, with [DIAGNOSES REDACTED]. Review of the Admission MDS dated [DATE], revealed under Section V, the Care Areas Assessment (CAA) Summary, communication and [MEDICAL CONDITION] medications had triggered for care planning. Review of the physician's orders [REDACTED]. Review of Resident #14's Comprehensive Care Plan, dated 04/14/14, revealed there was no documented evidence of care plans to address the resident's communication or [MEDICAL CONDITION] medication use. Interview, on 07/03/14 at 5:15 PM, with LPN #1/MDS Coordinator revealed the MDS Nurse was responsible for ensuring CAAs that triggered were addressed on the residents' care plans; however, she had not completed this resident's MDS and Care Plan. She stated the MDS Coordinator, who was responsible for completing this MDS and Care Plan, was unavailable for interview. Interview, on 07/03/14 at 5:30 PM, with Registered Nurse (RN) #2/Assistant Director of Nursing (ADON) revealed triggered areas on the CAA Summaries were to be addressed on the care plans by the MDS Nurses. RN #2/ADON stated the triggered areas for Resident #14 should have been care planned with interventions put in place, based on the MDS Assessment and the facility's policy. Interview, on 07/03/14 at 6:00 PM, with the Director of Nursing (DON) revealed it was the responsibility of the MDS Coordinators to ensure development of the care plan from the triggered areas on the CAA Summaries. 2. Review of Resident #16's medical record revealed the facility admitted the resident on 02/01/12 with [DIAGNOSES REDACTED]. Review of Resident #16's Significant Change Minimum Data Set (MDS) Assessment, dated 05/05/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status score of fifteen (15) out of fifteen (15), indicating the resident was alert and oriented. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) staff for bed mobility, transfers, and toileting, and as frequently incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 05/05/14, revealed the resident had decreased physical function and was at risk for inadequate completion of daily care needs and was frequently incontinent of bowel and bladder. Review of Resident #16's Comprehensive Care Plan, dated 09/2013, revealed the resident was care planned for episodes of incontinence and requiring staff assist for completion of daily care due to decreased physical function related to his/her [DIAGNOSES REDACTED]. The interventions included staff assist with bathing , dressing, and grooming as needed, staff assist with transfers, and staff assist with toileting. However, the Comprehensive Care plan was not developed with individualized interventions related to how many staff was required to assist with ADLs including; toileting, incontinence care, bed mobility and transfers. Review of the SRNA Care Plan dated 07/14, revealed the resident required one (1) staff for transfers, bed mobility, and toileting. Continued interview with LPN #1/MDS Coordinator, on 07/30/14 at 3:00 PM and review of the most recent MDS dated [DATE], and the SRNA Care Plan dated 07/14, revealed there was discrepancies in how many staff was required to assist with transfers, bed mobility, and toileting in comparison with the MDS and the SRNA Care Plan. She also indicated the Comprehensive Care Plan did not have specific individualized interventions, and did not specify how many staff was required to assist the resident with toileting, incontinence care, transfers, and bed mobility. Interview, on 07/24/14 at 1:30 PM, with Resident #16 revealed he/she usually went to the bathroom on his/her own as at times it had taken as long as forty-five (45) minutes for his/her call light to be answered. 3. Review of Resident #24's medical record revealed the facility admitted the resident on 05/21/14 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/21/14 revealed the facility assessed the resident as requiring extensive assistance of one (1) person for bed mobility, transfers, ambulation, dressing, toileting and personal hygiene. Further review, revealed the facility assessed the resident as occasionally incontinent of bowel and bladder. Review of the Comprehensive Plan of Care, dated 06/11/14, revealed the resident had a ADL Self Care Deficit and was at risk for complications related to the deficit and required assist with transfers. The goal stated the resident would maintain ADL self performance as evidenced by no decline, would not develop complications related to decreased ADL self care performance and would participate with care and be clean, groomed and dressed. The interventions included: staff to provide only the amount of assistance/supervision to meet the resident's needs for ADLs, turn and reposition, shifting weight to enhance circulation, and staff to assist with transfers as needed. However, the Care Plan was not developed with individualized interventions related to how many staff was required to turn and reposition the resident or how often this was to be done, or how many staff was required to assist with transfers or how the resident was to be transferred. Further review revealed the Comprehensive Care Plan, dated 06/11/14, stated the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean and dry, and would not develop any complications associated with incontinence. There were several interventions including; maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not developed with individualized interventions related to how many staff was required to toilet or assist with incontinence care, or how often the resident was to be toileted or receive incontinence care. Review of the SRNA Care Plan for Resident #24, dated 07/14, revealed the resident required the assistance of one for transfers, mobility and with toileting needs, and was continent of bowel and occasionally incontinent of bladder requiring the use of adult incontinence briefs. Further interview with LPN #1/MDS Coordinator, on 07/30/14 at 10:45 AM revealed the Comprehensive Care Plan was not developed with specific interventions related to ADLs and how much assistance was to be provided for transfers, toileting, incontinence care, and bed mobility and there was no specific interventions related to how often the toileting, incontinence care and turning and repositioning was to be done. Interview, on 07/25/14 at 9:30 AM, with Resident #24 revealed she had problems with call lights not being answered timely and he/she took himself/herself to the bathroom, and did not ask staff for help to do that. 4. Review of Resident #26's medical record revealed the facility admitted the resident on 07/23/12, with [DIAGNOSES REDACTED]. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating the resident was alert and oriented. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) staff for bed mobility, transfers, and toileting, and as frequently incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 06/23/14, revealed the resident had decreased physical function and was at risk for inadequate completion of daily care needs and was frequently incontinent of bowel and bladder. Review of Resident #26's Comprehensive Care Plan dated 06/16/14, revealed the resident had an Activities of Daily Living (ADLs) self care deficit and was at risk for complications related to this deficit and required assist in transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline, would not develop any complications related to decreased ADL self care performance and would participate in care and be clean, groomed and dressed through next review. There was several interventions including staff to provide only the amount of assistance/supervision needed to meet the resident's needs for all ADLs, turn and reposition shifting weight to enhance circulation, and staff to assist with transfers as needed. However, the Care Plan was not developed with individualized interventions related to how many staff were required or how often the resident was to be turned and repositioned, or how many staff was required to transfer the resident. Further review revealed the Comprehensive Care Plan dated 06/16/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, dry and comfortable daily, would not develop complications associated with incontinence and the resident's dignity would be maintained without embarrassment or fear through next review. There were several interventions including; maintain privacy and dignity when providing perineal care after each incontinence episode, and provide privacy and dignity when checking resident for incontinent episodes. However, the Care Plan was not developed with individualized interventions related to how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting. Interview with LPN #1/MDS Coordinator, on 07/30/14 at 10:45 AM, and review of the most recent MDS dated [DATE] with the SRNA Care Plan dated 07/14 for Resident #26, revealed the following; the MDS was coded as the resident requiring extensive assist of two (2) staff for transfer, and the SRNA care plan stated one to two (1-2) for transfer; the MDS coded two (2) staff for bed mobility and the SRNA care plan stated one (1) staff to reposition every two (2) to three (3) hours; the MDS coded two (2) staff for toileting and the SRNA care plan stated one (1) assist for toileting needs and specified the resident was incontinent of bowel and bladder. LPN #1 explained the MDS coding was for the most dependent, but the SRNA Care Plan did not necessarily have to code for the most dependent because the resident may not need that much support at all times. However, she stated for this resident the SRNA Care Plan

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13) was incorrect and should have stated two (2) staff for transfers, two (2) staff for toileting, and two (2) staff for turning and repositioning. Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed he/she had waited for over an hour for someone to respond to his/her call light before, and had pooped on himself/herself during the night before as a result of having to wait for staff's assistance. Resident #26 stated SRNA #19 had been assigned to his/her care the night before when he/she had pooped on himself/herself, and did not change him/her after he/she asked the SRNA to be changed. Resident #26 stated no one changed him/her until day shift reported to work that morning. During the interview, Resident #26 started crying and stated he/she felt like he/she wasn't supposed to be clean. The resident stated he/she felt staff did not want to change him/her. Interview, on 07/03/14 at 2:51 PM, with SRNA #20 revealed she had come in early that morning to escort Resident #26 to a doctor's appointment. SRNA #20 stated when she arrived she observed Resident #26 to be soiled and had a lot of bowel movement on him/her. SRNA #20 stated this was not normal for this resident who was able to request assistance when he/she needed to be changed. Interview, on 07/03/14 at 7:00 PM, with Registered Nurse (RN) #6 revealed the night before, she worked with SRNA #19 and SRNA #21. She stated the two (2) SRNAs did not work as a team that night, due to personal conflict. RN #6 stated she assisted SRNA #19 with changing, turning, and positioning the residents at 1:30 AM and 3:00 AM, that were care planned for requiring two (2) staff for assistance. She further stated she could not assist SRNA #19 with residents on the last round at 5:00 PM, as she had to complete her medication pass. RN #6 revealed SRNA #21 had a SRNA orientee working with her, who assisted her until the end of the shift. She reported Resident #26 asked to be changed about 5:30 AM, and she told SRNA #19 to change the resident as he/she was receiving intravenous (IV) fluids at seventy-five (75) milliliters (mls) per hour which caused him/her to urinate frequently. Continued interview with RN #6 revealed SRNA #19 told her (RN #6) she was working on getting the residents up and ready for breakfast. RN #6 explained the night shift staff was responsible for getting certain residents up and ready for breakfast. RN #6 stated the conflict between SRNA #19 and SRNA #21 impacted the residents' care that night. She stated she should have told SRNA #19 that getting the residents up out of bed was not as important as tending to residents who were asking for care since she was her supervisor. Per interview, RN #6 revealed she knew Resident #26 needed to be changed on the last rounds; however, she had not ensured this was done. She revealed it would be terrible not to be changed when wet or soiled with stool, and the facility provided training on neglect as a form of abuse. However, she reported she had not taken her concern to Administration, but should have. Interview, on 07/23/14 at 9:08 AM, with SRNA #19 revealed she did not feel comfortable providing incontinence care for Resident #26 by herself because the resident's legs were stiff and he/she would slide when standing up and holding on to the transfer pole from the recliner chair in which she slept at night. She stated she changed the resident the last time on the morning of 07/03/14 at 4:30 AM or 5:30 AM, and the resident rang the call light at 6:30 AM wanting to be changed again. She further stated she was unable to find anyone to assist with providing incontinence care to Resident #26 during the last rounds because RN #6 was busy and SRNA #21 had ignored her when she requested assistance. Further interview revealed she did not return to Resident #26's room prior to leaving for the shift; however she told SRNA #9 and SRNA #6 who had come on shift, the resident needed changed. 5. Review of Resident #30's medical record revealed [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/05/14, revealed the facility assessed the resident as having a BIMS of five (5) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons with bed mobility, transfers, and toileting, and as frequently incontinent of urine and occasionally incontinent of bowel. Review of the CAA, dated 05/05/14, revealed the resident had decreased cognitive and physical function. Review of the Comprehensive Plan of Care, dated 06/10/14, revealed the resident had a ADL Self Care Deficit and was at risk for complications related to the deficit and required assist with transfers. The goal stated the resident would maintain ADL self performance as evidenced by no decline, would not develop complications related to decreased ADL self care performance and would participate with care and be clean, groomed and dressed. The interventions included: staff to provide only the amount of assistance/supervision to meet the resident's needs for ADLs, turn and reposition, shifting weight to enhance circulation, and staff to assist with transfers as needed. However, the Care Plan was not developed with individualized interventions related to how many staff was required to turn and reposition the resident or how often this was to be done, or how many staff was required to assist with transfers or how the resident was to be transferred. Further review revealed the Comprehensive Care Plan, dated 06/10/14, stated the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean and dry, and would not develop any complications associated with incontinence. There were several interventions including: maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not developed with individualized interventions related to how many staff was required to toilet or assist with incontinence care, or how often the resident was to be toileted or receive incontinence care. Review of the SRNA Care Plan, dated 07/14, revealed the resident required the assistance of one (1) staff for transfers, mobility, and tuning and repositioning, and required the assistance of one (1) staff for toileting in the bathroom every two (2) to three (3) hours while awake and prn (as needed). Continued interview with LPN #1/MDS Coordinator, on 07/30/14 at 1:40 PM and review of the MDS and SRNA Care Plan revealed there were discrepancies in how many staff were needed to assist the resident with ADL's including transfers, bed mobility, and toileting in comparing the MDS and SRNA Care Plan. Further interview revealed the Comprehensive Care Plan was not developed with specific interventions related to ADLs and how much assistance was to be provided for transfers, toileting, incontinence care, and bed mobility and there was no specific interventions related to how often the toileting, incontinence care and turning and repositioning was to be done. 6. Review of Resident #31's medical record revealed [DIAGNOSES REDACTED]. Review of the Annual MDS Assessment, dated 07/06/14, revealed the facility assessed the resident as having a BIMS of fourteen (14) out of fifteen (15), indicating the resident was alert and oriented. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for bed mobility, transfers, and toilet use, and as frequently incontinent of urine and always incontinent of bowel. Review of the Care Area Assessment (CAA) dated 12/20/13, revealed the resident required assistance with transfers due to significant generalized weakness and self reports incontinence of bowel. Review of the Comprehensive Plan of Care, dated 07/06/14, revealed the resident had a ADL Self Care Deficit and was at risk for complications related to the deficit and required assist with transfers. The goal stated the resident would maintain ADL self performance as evidenced by no decline, would not develop complications related to decreased ADL self care performance and would participate with care and be clean, groomed and dressed. The interventions included: staff to provide only the amount of assistance/supervision to meet the resident needs for ADLs, turn and reposition, shifting weight to enhance circulation, staff to assist with transfers as needed, and two (2) person lift required for transfers. However, the Care Plan was not developed with individualized interventions related to how many staff was required to turn and reposition the resident or how often this was to be done. Further review revealed the Comprehensive Care Plan, dated 07/06/14, stated the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean and dry, and would not develop any complications associated with incontinence. There were several interventions including: maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not developed with individualized interventions related to how many staff was required to toilet or assist with incontinence care, or how often the resident was to be toileted or receive incontinence care. Review of the SRNA Care Plan, revealed the resident required the assistance of one (1) with mobility, two (2) for transfers, and two (2) for turning and repositioning. Further review revealed the resident required the assist of one (1) or two (2) for toileting needs, was to be checked and changed every two (2) to three (3) hours and was to be encouraged to use the toilet. Further interview with LPN #1/MDS Coordinator, on 07/30/14 at 1:40 PM and review of the most recent MDS dated [DATE] in comparison with the SRNA Care Plan dated 07/14, revealed there were discrepancies in how many staff was required to assist with toileting and bed mobility. She also indicated the Comprehensive Care Plan did not have specific individualized interventions, and did not specify how many staff was required to assist the resident with toileting, incontinence care, and bed mobility. Continued interview with LPN #1/MDS Coordinator, on 07/27/14 at 11:05 AM, and 07/30/14 at 10:45 AM and 4:30 PM revealed through the winter she had completed all MDSs in the building and this went on for several months, and since that point her job was to do the MDS on South Unit as well as develop the Care Plans for the South Unit. She stated she had no formal training related to developing care plans but gathered information to write the care plan from the MDS, the ADL Reports which showed the amount of assistance the resident required for ADLs the past seven (7) days prior to the MDS, looked at physician's orders [REDACTED]. She stated the Comprehensive Care Plans did not need to be developed with individualized interventions related to how much ADL support was to be provided (how many staff was needed to provide the care) on the comprehensive care plan because staff could refer to the SRNA Care Plan for this information. She further stated staff would not know how

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) to care for the residents just by looking at the Comprehensive Care Plan related to the resident's ADLs. Continued interview revealed she was revising the SRNA Care Plan until 02/01/14, and then it was the ADON's responsibility to ensure they were revised with any changes needed and also reviewed monthly. However, she stated she did not communicate changes to the ADON when completing MDS Assessments. Interview with RN #4/ADON on South Unit, on 07/31/14 at 8:26 AM, revealed she took the SRNA Care Plans to the morning meetings along with a copy of the previous days physician's orders [REDACTED]. She stated she then went to the unit and updated the SRNA Care Plan in the SRNA Book at the desk and on the back of the resident's door. She further stated for new admissions, she would review any information from the hospital for any Physician information, physician's orders [REDACTED]. Further interview revealed she did not use the MDS to get information for the SRNA Care Plan, and also did not review the Comprehensive Care Plan when reviewing or updating the SRNA Care Plans. She stated, she had reviewed the Comprehensive Care Plans this week and felt they should be more specific as far as functional status to show how many staff were required to turn and reposition, to transfer, and to toilet and provide incontinence care. RN #4/ADON, stated it was her understanding that the MDS was a picture of the resident's health and the MDS information should be used to develop the Comprehensive Care Plan. Continued interview revealed, she felt the Comprehensive Care Plans should match the SRNA Care Plans. She stated she had never compared the MDS, the Comprehensive Care Plans and the SRNA Care Plans until this was brought up during survey. Interview with the Director of Nursing (DON), on 08/01/14 at 9:00 AM, revealed, The care plan should mirror the individual. She stated it would be important to make sure the care plans were developed according to MDS guidelines. She further indicated the Comprehensive Care Plans should be individualized to meet the residents' needs and staff should be able to take care of the resident by looking at the Comprehensive Care Plan. Further interview revealed the Comprehensive Care Plans should be specific as to how many staff was required for transfers, toileting, ADLs, incontinence care, bed mobility and should also match the SRNA Care Plan in order for staff to provide the correct care for the residents. She stated during survey, she realized the Comprehensive Care Plans were not individualized with specific interventions related to ADLs and did not match the SRNA Care Plans. She also stated, that during the survey she realized the SRNA Care Plans were not correct and did not match the MDSs in how much assistance the resident required. Continued interview revealed the SRNA Care Plans should match the Comprehensive Care Plan. However, she stated the MDS did not always have to match the Comprehensive Care Plan because a person may require more assistance at one time of the day than another time, and this would need to be explained on the Comprehensive Care Plan. The DON stated the Interdisciplinary (IDT) Comprehensive Care Plan should be developed in collaboration with the MDS Coordinators, the nurses, the ADONs and the SRNAs. However, she stated due to turn over in MDS Coordinators and ADONs this was not always done. Interview with the former Administrator, on 07/31/14 at 10:14 AM, who was the Administrator from 05/15/14 until 07/11/14 revealed the facility had noted the care plans were not accurate prior to the survey and they had discussed this in the morning meetings. She stated they put together a team to look at MDSs due to an internal audit showing a concern and the ADONs were reviewing the care plans for completeness. However, she stated she did not know if the care plans were specific related to functional status because she did not review them.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the Resident Assessment Instrument (RAI) Manual 3.0 Version, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was reviewed and revised for twelve (12) of thirty-seven (37) sampled residents (Residents #5, #8, #11, #17, #24, #27, #28, #29, #32, #33, #36 and #37). Review of the Comprehensive Plans of Care for Residents #5, #8, #27, #28, #29, #36, #33, #17, #32, and #37 revealed the Care Plans were not revised to include specific interventions related to how many staff were required and/or how often the residents were to be toileted, receive incontinence care, be turned and repositioned, and/or be transferred in order for staff to provide the care indicated as required on the Quarterly Comprehensive Assessment. In addition, the facility failed to ensure the Comprehensive Care Plan was revised for Resident #11 when the resident was diagnosed with [REDACTED]. Also, the facility failed to ensure the Comprehensive Care Plan was revised for Resident #24 related to physician's orders [REDACTED]. The findings include: Review of the facility's policy titled, Care Plans-Comprehensive, revised 10/10, revealed Assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition changed. The Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when there was a significant change in the resident's condition, when the desired outcome was not met, when the resident was readmitted to the facility from a hospital stay, and at least quarterly. Review of the facility's policy titled, Interdisciplinary Team Care Assessments, dated 12/10, revealed each resident of the facility would have a plan of care. Continued review of the policy revealed changes in a resident's condition often required changes to be made to the care plan either by change in individual approaches or by the addition of new problems to the care plan. Further review revealed when changes in a resident's condition, medications, treatments or approaches occurred staff was to update the care plan immediately by hand and written on the hard copy until it could be updated in the computer. Review revealed once the care plan had been updated in the computer, a copy was to be printed and placed in the resident's medical record. Review of the Resident Assessment Instrument Version 3.0 Manual, (section 4.1) revealed the results of the assessment which must accurately reflect the resident's status and needs, are to be used to review and revise each resident's Comprehensive Plan of Care. Section 4.7 revealed the Care Plan must be reviewed and revised periodically and services provided or arranged must be consistent with each resident's written plan of care. Interview with Licensed Practical Nurse (LPN) #1 on 07/27/14 at 11:05 AM, revealed she was the Minimum Data Set (MDS) Coordinator, who was in charge of completing the MDSs and developing the Care Plans on the South Unit until 07/03/14. However, she stated since February 2014 she was no longer responsible for revising the Care plans with the Quarterly Assessments. She stated the Director of Nursing (DON) and the two (2) Assistant Directors of Nursing (ADONS) as well, as other members from the clinical meeting were updating the Care Plans for the Quarterly Assessments. She further stated the floor nurses were responsible for updating the Care Plans daily with physician's orders [REDACTED]. Continued interview with LPN #1 revealed the Care Plan did not need revisions with the Quarterly Assessment to indicate how many staff were required to assist with ADLs such as transfers, bed mobility, toileting, and incontinence care or how often the assistance was needed because this was specified on the State Registered Nursing Assistant (SRNA) Care Plan Record which was a part of the permanent record and updated at least monthly by the ADONs. Interview on 07/31/14 at 8:26 AM,with Registered Nurse (RN) #4/ADON on the South Unit, revealed the MDS Coordinators were responsible for updating the Care Plans for MDSs including Significant Change, Annuals, Admissions, and Quarterlies and she was responsible for updating the SRNA Care Plans as well. Interview with the DON, on 08/01/14 at 9:00 AM, revealed the MDS Nurse was responsible for updating the Care Plans for the Quarterly Assessments and the ADONs, MDS Nurse, the floor nurses, and the SRNAs should work together to ensure the Care Plans were accurate. She further stated, the nurses on the floor could update the care plans daily with changes in resident's condition or physician's orders [REDACTED]. 1. Review of Resident #5's medical record revealed the facility readmitted the resident on 04/10/14, with [DIAGNOSES REDACTED]. Review of Resident #5's Quarterly MDS Assessment, dated 05/15/14, revealed the facility assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of four (4). Further review of the MDS revealed the facility assessed the resident as requiring extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers, and toileting and as always incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 04/17/14, revealed the resident required assistance with toileting, had episodes of incontinence, and staff would provide incontinence care as indicated. Further review revealed staff was to assist with transfers and mobility. Review of Resident #5's Comprehensive Care Plan, dated 02/06/14 revealed the resident had an Activities of Daily Living (ADLs) self care deficit and was at risk for complications related to the deficit and required assistance with transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including; staff to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, turn and reposition to enhance circulation, and staff to assist with two (2) person lift during transfers. However, the Care Plan was not revised to indicate individualized interventions related to how many staff were required or how often the resident was to be turned and repositioned. Further review revealed the Comprehensive Care Plan dated 02/16/14, revealed the resident required extensive assistance with bed mobility with a goal the resident would have intact skin. The interventions included assist prn (as needed) to reposition/shift weight to relieve pressure. However, the Care Plan was not revised to indicate individualized interventions related to how many staff were required for bed mobility or how often the resident was to be repositioned. Continued review revealed the Comprehensive Care Plan dated 02/16/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, would not develop any complications associated with incontinence and dignity would be maintained without embarrassment or fear. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised to indicate individualized interventions related to how many staff were required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting. In reviewing the most recent MDS dated [DATE], with the SRNA Care Plan dated July 2014, for Resident #5 with LPN #1, the following was noted; the MDS was coded for extensive assist of two (2) staff for transfer, and the SRNA Care Plan stated assist of one (1) to two (2) staff for transfers; the MDS was coded for extensive assist of two (2) staff for bed mobility, and the SRNA Care Plan stated one (1) to two (2) staff to reposition every two (2) to three (3) hours; the MDS was coded for extensive assistance of two (2) for toileting and the SRNA Care Plan stated assist of one (1) to two (2) to toilet and check and change every two (2) to three (3) hours and as needed. LPN #1 stated there were discrepancies in ADL support needed with the MDS and the SRNA Care Plan. Further interview revealed the Comprehensive Care Plan was not revised with individualized interventions to indicate how many staff was required for bed mobility or how often the resident was to be repositioned. She further indicated the Comprehensive Care Plan was not revised to indicate how many staff was required for incontinence care and toileting, or how often the resident was to receive incontinence care and toileting. Interview, on 07/23/14 at 9:08 AM with SRNA #19, revealed there were usually two (2) aides on the night shift on the South Unit where Resident #5 resided, and if a resident required two (2) to assist she would get the nurse to help rather than work with SRNA #21 due to a conflict with her. She stated she could get the nurses to help her until last rounds which usually started about 6:00 AM, and sometimes the nurses could assist her with last rounds as well. Continued interview revealed there were seven (7) residents on her side of the South Unit who required two (2) staff to assist with incontinence care. She further stated maybe one (1) or two (2) times a month she would be unable to find someone to assist her with last rounds for these residents because some nurses would not make SRNA #21 assist her. SRNA #19 stated Resident #5 walked to the bathroom with assistance and she took the resident to the bathroom about 5:30 AM on the morning of 07/03/14 and the resident was not wet when she left. Interview with SRNA #9 on 07/23/14 at 1:52 PM, revealed on the morning of 07/03/14 when she arrived on the unit she found Resident #5 in the bed and the resident as well as the bed linens were soaking wet. She stated every time she followed SRNA #19 when she worked with SRNA #21, she found residents soaking wet with urine. 2. Record review revealed the facility admitted Resident #8 on 10/16/12, with [DIAGNOSES REDACTED]. Review of Resident #8's Quarterly Minimum Data Set (MDS) Assessment, dated 03/20/14, revealed the facility assessed the resident as requiring one (1) person assist for bed mobility, transfer, and toilet use. Review of the Comprehensive Care Plan, dated 06/17/14, revealed Resident #36 was care planned for ADL self care deficit. The goal stated the resident would maintain ADL self performance levels, the resident would not develop complications related to decreased ADL self performance, and the resident would participate with care. The interventions included: staff to provide only the amount of assistance/supervision to meet the residents needs, and staff to assist with transfers as needed, and turn and reposition shifting weight. However, the Comprehensive Care plan was not revised with individualized interventions related to the specific information on the required number of staff assist needed for transfers and bed mobility, and how often the resident was to be turned and repositioned. Further review of the Comprehensive Care Plan dated October 2013, revealed the resident required assist with ADLs due to decreased physical function. The goal stated the resident would have needs met via staff assist. The interventions included assisting with daily care as needed, and assist with toileting needs at least every two (2) to three (3) hours. However, the Care Plan was not revised to include individualized interventions related to how many staff were required to assist with toileting. Review of the SRNA Care Plan, dated July 2014 revealed the resident required the assist of one (1) staff for transfers, toileting, and bed mobility. Interview with LPN #1, on 07/30/14 at 3:20 PM, revealed the Comprehensive Plan of Care was not revised with individualized interventions related to the required number of staff needed to assist with toileting and incontinence care, transfers, and bed mobility. In addition, the Care Plan was not specific as to how often the resident was to be turned and repositioned. 3. Review of Resident #17's medical record revealed the facility admitted the resident on 09/10/13, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed Resident #17 as requiring the extensive assist of two (2) staff for bed mobility, transfers, and toilet use. Review of the Comprehensive Care Plan dated 04/08/13, revealed the resident had an ADL self care deficit as evidenced by need for assistance with ADLs related to Non-Hodgkin [MEDICAL CONDITIONS] and Depression. The goals stated the resident would not develop any complications related to decreased ADL self performance, would maintain ADL self performance levels, and would participate with care and be clean, groomed, and dressed. The interventions included; provide only the amount of assist/supervision to meet needs for all ADLs, assist with ADLs as needed, turn and reposition, shifting weight to enhance circulation, and staff assist with sliding board. However, the Care Plan was not revised with individualized interventions related to how many staff was required to assist with transfers with the sliding board, and how many staff was required to assist with turning and repositioning or how often the resident was to be turned and repositioned. Further review of the Comprehensive Care Plan dated October 2013 revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goal stated the resident would not develop any complications associated with incontinence. The interventions included: maintain privacy and dignity when checking for incontinent episodes. However, the Care Plan was not revised to include individualized interventions regarding how the resident was to be toileted, how often the resident was to be toileted or how many staff was required to assist with toileting. Review of the SRNA Care Plan dated July 2014, revealed the resident required the assist of one (1) staff with the sliding board, required the assist of two (2) staff for turning and repositioning every two (2) to three (3) hours. Further review revealed the resident required the assist of two (2) for toileting, wore adult briefs and was to be toileted every two (2) to three (3) hours while awake and as needed. Interview with LPN #1, on 07/30/14 at 2:15 PM, and review of the MDS dated [DATE]; and, the SRNA Care Plan dated July 2014 revealed the Comprehensive Care Plan was not revised with individualized interventions related to how many staff was required to transfer the resident with the sliding board, how many staff was required to assist the resident with bed mobility, or how often the resident was to be turned and repositioned. Further interview revealed the Care Plan was not revised to include individualized interventions regarding how the resident was to be toileted, how often the resident was to be toileted or how many staff was required to assist with toileting. 4. Review of Resident #27's medical record revealed the facility admitted the resident on 06/14/13, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 05/21/14, revealed the facility assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status of three (3) indicating severe cognitive impairment. Further review of the MDS revealed the facility assessed the resident to require extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers, and toileting and as being frequently incontinent of bowel and bladder. Review of the Care Areas Assessment (CAA) dated 02/18/14, revealed the resident had frequent urinary incontinence and required assist with toileting as needed and perineal care after each incontinent episode, and was to be assisted with bed mobility as needed. Review of Resident #27's Comprehensive Care Plan dated 05/28/14, revealed the resident had an Activities of Daily Living (ADL's) self care deficit and was at risk for complications related to the deficit and required assistance with transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including; staff was to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, turn and reposition to enhance circulation, and a two (2) person lift required during transfers. However, the Care Plan was not revised with individualized interventions related to how many staff were required to turn and reposition the resident or how often the resident was to be turned and repositioned. Continued review

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 16) revealed the Comprehensive Care Plan dated 05/28/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, would not develop any complications associated with incontinence and dignity would be maintained without embarrassment or fear. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised with individualized interventions related to how many staff were required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting. Review of the most recent MDS dated [DATE], with the SRNA Care Plan dated 07/14 for Resident #27 with LPN #1 on 07/30/14 at 10:45 AM, the following was noted; the MDS was coded for extensive assist of two (2) for transfers, and the SRNA Care Plan stated assist of one (1) for transfers, the MDS coded extensive assist of two (2) for bed mobility, and the SRNA Care Plan stated one (1) staff was required to reposition every two (2) to three (3) hours and as needed, the MDS coded for extensive assist of two (2) for toileting and the SRNA Care Plan stated assist of one (1) to take to the bathroom before meals, at night and as needed. LPN #1 acknowledged there were discrepancies in the level of ADL support needed on the MDS in comparison with the SRNA Care Plan. LPN #1 further acknowledged the Comprehensive Care Plan was not revised, with individualized interventions, to indicate how many staff was required or how often the resident was to be turned and repositioned, how often the resident was to be toileted, and how many staff was required to assist the resident to the toilet. Interview, on 07/23/14 at 9:08 AM with SRNA #19 revealed she had performed incontinence care on Resident #27 during last rounds on the morning of 07/03/14 because he/she did not require two (2) to assist with incontinence care. Interview, on 07/23/14 at 1:52 PM, with SRNA #9 revealed on the morning of 07/03/14 she found Resident #27 about 7:00 AM wet with a brown ring on the sheets around the resident which indicated the resident had not received incontinence care for many hours. 5. Review of Resident #28's medical record revealed the facility admitted the resident on 03/06/13, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS, dated [DATE], revealed the facility assessed the resident to be cognitively impaired with a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicating the resident was cognitively impaired. Further review of the MDS revealed the facility assessed the resident to require extensive physical assistance of two (2) staff for most of his/her ADLs including bed mobility and transfers, and extensive assistance of one (1) staff for toileting and as frequently incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 12/24/13, revealed the resident used the bathroom for toileting needs. Review of Resident #28's Comprehensive Care Plan dated 06/03/14, revealed the resident had Activities of Daily Living (ADL's) self care deficit and was at risk for complications related to the deficit. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including staff was to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, and turn and reposition to enhance circulation. However, the Care Plan was not revised with individualized interventions to indicate how many staff were required to turn and reposition the resident or how often the resident was to be turned and repositioned, and how many staff was required for transfers. Continued review revealed the Comprehensive Care Plan dated 06/03/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, and would not develop any complications associated with incontinence. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised with individualized interventions related to how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting. In reviewing the most recent MDS dated [DATE], with the SRNA Care Plan dated July 2014 for Resident #28 with LPN #1, on 07/30/14 at 10:45 AM, the following was noted; the MDS was coded for extensive assist of two (2) for transfer, and the SRNA Care Plan stated assist of one (1) to transfer; the MDS was coded for extensive assist of two (2) for bed mobility and the SRNA Care Plan stated the resident was to be turned and repositioned every two (2) to three (3) hours with the assist of one (1). LPN #1 acknowledged there were differences in the ADL support needed for transfers, and bed mobility with the MDS and SRNA Care Plan. She further indicated the Comprehensive Care Plan was not revised as to how often to turn and reposition the resident or how much assistance was needed, or how the resident was to be transferred and how much assistance was needed. She further stated the Comprehensive Care Plan was not revised to specify if the resident was to be checked and changed, assisted to the toilet, or how often the resident required incontinence care and toileting. Interview on 07/23/14 at 9:08 AM with SRNA #19, revealed she had performed incontinence care for Resident #28 on the last rounds the morning of 07/03/14. However, interview with SRNA #9 on 07/23/14 at 1:52 PM, revealed shortly after 7:00 AM, she found Resident #28 with an extremely soaked brief. 6. Review of Resident #29's medical record revealed the facility admitted the resident on 09/28/12, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 07/07/14, revealed the facility assessed the resident to be severely cognitively impaired. Further review of the MDS revealed the facility assessed Resident #29 to require extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers, toilet use and as always incontinent of bowel and bladder. Review of the Care Area Assessment (CAA) dated 03/25/14, revealed the resident had decreased physical and cognitive impairment. Review of Resident #29's Comprehensive Care Plan dated 06/01/14 revealed the resident had an Activities of Daily Living (ADL's) self care deficit and was at risk for complications related to the deficit requiring assistance with transfers. The goals stated the resident would maintain ADL self performance levels as evidenced by no decline in stated level, would not develop any complications related to decreased ADL self care performance, and would participate with care and be clean, groomed and dressed. There were several interventions including; staff to provide only the amount of assistance/supervision needed to meet the resident's needs with ADLs, turn and reposition to enhance circulation and a two (2) person lift required during transfers. However, the Care Plan was not revised with individualized interventions to indicate how many staff were required to turn and reposition the resident or how often the resident was to be turned and repositioned. Continued review revealed the Comprehensive Care Plan dated 06/01/14, revealed the resident had the potential for complications associated with incontinence of bowel and/or bladder. The goals stated the resident would be kept clean, and dry, and would not develop any complications associated with incontinence, and the resident's dignity would be maintained without embarrassment or fear. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not individualized with individualized interventions to indicate how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting. In reviewing the most recent MDS dated [DATE], with the SRNA Care Plan dated 07/14 for Resident #29 with LPN #1, on 07/30/14 at 10:45 AM, the following was noted; the MDS coded extensive assistance of two (2) for bed mobility, and the SRNA Care Plan stated assist of one (1) to two (2) to reposition every two (2) to three (3) hours. LPN #1 indicated there was discrepancies in the level of ADL support required for the MDS and SRNA Care Plan related to bed mobility. Further interview with LPN #1 revealed the Comprehensive Care Plan was not revised related to how many staff was required to turn and reposition the resident or how often the resident was to be turned, how many staff was required for incontinence care and toileting, and how often the resident was to receive incontinence care and toileting. Interview on 07/03/14 at 5:53 PM with LPN #8 revealed she observed Resident #29 to be beyond soaked the morning of 07/03/14 and indicated the resident appeared to not have been changed throughout the night. Interview on 07/23/14 at 9:08 AM with SRNA #19, revealed on the morning of 07/03/14 for the last round of the night shift, she did not perform incontinence care for Resident #29. She stated the resident should have received incontinence care at 5:00 AM; however, she was unable to find anyone to assist her with Resident #29 who required the assistance of two (2) staff for incontinence care. She explained this was because RN #6 was busy administering medications and due to a conflict with SRNA #21 who would not work with her. Interview, on 07/03/14 at 7:00 PM, with RN #6 revealed the night before, she worked with SRNA #19 and SRNA #21. She stated the two (2) SRNAs did not work as a team that night, due to personal conflict. RN #6 stated she assisted SRNA #19 with changing, turning, and positioning the residents at 1:30 AM and 3:00 AM; she stated they were care planned for requiring two (2) staff for assistance. She stated she could not assist SRNA #19 with residents on the last round at 5:00 PM, as she had to complete her medication pass. RN #6 stated the conflict between SRNA #19 and SRNA #21 impacted the residents' care that night. 7. Review of Resident #32's medical record revealed the facility admitted the resident on 05/24/13, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14) which indicated no cognitive impairment. Continued review of the MDS Assessment revealed the facility assessed Resident #32 to require extensive assistance of two (2) staff for bed mobility, transfers, and toilet use. Review of the Comprehensive Care Plan dated June 2014, revealed the resident had a ADL self care deficit as evidenced by assistance

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 17) required with ADLs related to a history of a [MEDICAL CONDITIONS] with Right [MEDICAL CONDITION]. The goal stated the resident would not develop complications related to decreased ADL self care performance. There were several interventions including provide only the amount of assistance needed to meet needs for all ADLs, turn and reposition prn (as needed), shifting weight to enhance circulation, and assist with transfers as needed. However, the Care Plan was not revised with individualized interventions related to how many staff was required to assist with turning and repositioning and transfers. In addition, the Care Plan was not revised to state how often the resident was to be turned and repositioned. Further review of the Comprehensive Care Plan, dated June 2014, revealed the resident had the potential for complications associated with incontinence of bowel and bladder. The goal stated the resident would not develop complications with incontinence. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the Care Plan was not revised with individualized interventions related to how many staff was required to assist with toileting and incontinence care. In addition, the Care Plan was not revised to state how often the resident was to be toileted or receive incontinence care. Review of the SRNA Care Plan dated July 2014, revealed the resident required a stand up lift for transfers using two (2) staff, was to be turned and repositioned every two (2) to three (3) hours with the assist of two (2) staff, and required the assist of two (2) staff for toileting, wore adult briefs and was to be toileted every two (2) to three (3) hours while awake and as needed. Interview and review of the Comprehensive Care Plan with LPN #1, on 07/30/14 at 1:40 PM revealed Resident #32's Care Plan was not revised with specific interventions related to how many staff was required to assist with turning and repositioning and transfers, how often the resident was to be turned and repositioned, or how often the resident was to be toileted and receive incontinence care. 8. Review of Resident #33's medical record revealed [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for bed mobility, transfers, and toilet use. Review of the Comprehensive Plan of Care, dated 05/19/14 revealed the resident had the potential for complications associated with incontinence of bowel/bladder. The goal stated the resident would be kept clean, dry and comfortable, and the resident would not develop any complications associated with incontinence. There were several interventions including maintain privacy and dignity when providing perineal care after each incontinent episode. However, the care plan was not revised with individual interventions related to how often the resident was to be toileted or receive incontinence care or how many staff was required to assist. Further review of the Comprehensive Pla
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the facility's policy and review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, revised October 2010, it was determined the facility failed to ensure the administration of medications met professional standards of quality for one (1) of thirty-seven (37) sampled resident (Resident #8) and one (1) of five (5) residents observed during the medication pass (Unsampled Resident B). Observation revealed Licensed Practical Nurse (LPN) #5 took medications for Unsampled Resident B into the resident's room and left the medications in the cup on his/her table. The LPN did not ensure the resident took the medications before leaving the room. In addition, interview with Resident #8 revealed he/she woke up at times, and his/her medications were in a medication cup on his/her table in the resident's room. The findings include: 1. Review of the facility's, Medication Administration Policy, effective December 2010, revealed under guideline, never leave any drug in a resident's room. Continued review revealed under procedure medication administration personnel would bring medication to the resident's bedside; identify the resident by name and identification bracelet or picture; read the label three (3) times before administering the medication; review the five (5) rights of medication administration; administer the medication; and remain in the room while the resident took the medication. Review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, revised October 2010, revealed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were responsible for the administration of medication or treatment as authorized by a Physician, Physician Assistant, or Advanced Practice Registered Nurse (APRN). Review revealed components of medication administration included, but were not limited to, preparing and giving medication in the prescribed dose, route and frequency. Review of Unsampled Resident B's medical record revealed the facility admitted the resident on 09/16/08, with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of a thirteen (13) out of fifteen (15), indicating no cognitive impairment. Further review of the record revealed no documented evidence the facility had completed an assessment for self administration of medications for Unsampled Resident B. Observation, on 07/02/14 at 7:40 AM, revealed LPN #5 checked the Electronic Medication Administration Record [REDACTED]. The medications included: [MEDICATION NAME]/Apap 7.5/325 milligrams (narcotic pain medication), Aspirin 81 milligrams (used for pain, inflammation, fever, and [MEDICAL CONDITION]), [MEDICATION NAME] Sodium 250 milligrams (stool softener), [MEDICATION NAME] 10 milligrams (antihypertensive), [MEDICATION NAME] 5 milligrams (allergy medication), Atorvastatin 40 mg (cholesterol lowering medication), [MEDICATION NAME] 20 milligrams (antidepressant medication), [MEDICATION NAME] 325 milligrams (used to treat [MEDICAL CONDITION]), [MEDICATION NAME] 150 milligrams (used to treat GERD), and Thera Multivitamin (vitamin supplement). Continued observation, on 07/02/14 at 7:50 AM, revealed LPN #5 took the cup of medications to Unsampled Resident B, and left the cup of medications and a cup of water on the bedside table. Observation revealed Unsampled Resident B was sitting on the bed, and the nurse reminded him/her to take the medications. Observation revealed LPN #5 then washed her hands and exited the room to sign off the medications on the E-MAR, without ensuring Unsampled Resident B took the medications and leaving the medications unattended. Further observation revealed Unsampled Resident B took the cup of medications and emptied them out on the bedside table, telling the Surveyor he/she could not swallow them all at one time. Interview with LPN #5, on 07/02/14, immediately after her exit from Unsampled Resident B's room, revealed the resident took too long to take his/her pills, and she just checked back with him/her later to ensure he/she had taken the medications. Further interview revealed there were some wandering residents in the building, but she would be in the hallway to observe if any other residents wandered into Unsampled Resident B's room. 2. Review of Resident #8's medical record revealed the facility admitted the resident on 10/16/12, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment dated [DATE], revealed a BIMS score of fifteen (15) out of fifteen (15) which indicated the resident was cognitively intact and interviewable. Interview with Resident #8, on 07/01/14 at 4:00 PM, revealed one (1) or two (2) times when he/she awakened, medications in a cup had been left on his/her bedside table. Resident #8 stated he/she had observed other residents wandering into the wrong room before and was concerned they might take his/her medication while he/she was sleeping. Interview with SRNA #6 on 07/02/14 at 3:20 PM, revealed she had not seen any medication on any resident's bedside table; however, Resident #8 had told her his/her medication had been left on the bedside table before. Interview with the RN #5/Evening Supervisor, on 07/02/14 at 3:30 PM, revealed it was her expectation for all nurses to be compliant in following the accepted standards of medication administration which were to ensure medication was administered in the presence of the nurse. She stated under no circumstances should a nurse place medication in a cup on a bedside table and leave it unattended. Continued interview revealed she felt education should be provided to the nursing staff, and any infraction referred to the Director of Nursing (DON) for further action. Interview with the DON on 07/02/14 at 9:20 AM and at 4:40 PM, revealed all nurses were to follow physician's orders [REDACTED]. The DON stated staff was to observe residents take their medication and medications were not to be left at the bedside. According to the DON, it would be a major problem if medications were left unattended in a resident's room and a wandering resident wandered into that room. She stated the Staff Development Nurse (SDN) checked staff off on administration of medications during orientation. The DON stated when the facility recently changed over to the E-MAR, all nurses and Certified Medication Aides (CMAs) were observed performing medication pass. Interview, on 07/02/14 at 10:30 AM, with the SDN revealed she observed new staff on medication pass during orientation, and randomly observed medication pass about every two (2) weeks for different staff. Continued interview revealed pharmacy had observed medication pass with the conversion to the new E-MAR system. The SDN stated she had not observed staff leaving medication at the bedside before; however, indicated it could be a problem if this were done as some residents wandered. She submitted a list of sixteen (16) residents who had been assessed to be at risk for wandering/elopement, and stated three (3) of those residents were known to wander into other residents' rooms.
F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **Provide care by qualified persons according to each resident's written plan of care.**

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 18) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure services provided were in accordance with each resident's Comprehensive Care Plan, or the Interim Care Plan, for six (5) of thirty-seven (37) sampled residents. (#16, #17, #26, #32 and #35). Resident #17, who had a history of [REDACTED]. Interventions included monitoring the resident's bowel elimination status, reporting changes in bowel status to Physician, and administering and monitoring the effectiveness of bowel medications. However, Resident #17 had a period of greater than three (3) day period, from 07/15/14 through 07/19/14, with no documented evidence of a BM, and no documented evidence of assessment and monitoring of the resident's bowel elimination status as directed by the care plan. On 07/19/14 at 10:02 PM, Resident #17 received a PRN bowel medication with no documented evidence of results and/or monitoring or assessing by nurses according to the care plan. On 07/20/14, at 10:20 AM, Resident #17 complained of abdominal pain, and began to vomit bright red blood. The Physician was notified and the resident was transported to the hospital emergency room (ER), where after assessment and diagnostic testing, the resident was diagnosed with [REDACTED]. Resident #32 also had a care plan related to ensuring the resident had a bowel movement (BM) every three (3) days; however, the resident experienced three (3) periods of time, between 06/25/14 and 07/18/14, of going greater than three (3) days without a documented BM, as per the care plan goal. In addition, there was no documented evidence Resident #32 was assessed and monitored, and PRN (as needed) bowel medications were administered as directed by the care plan. On 05/15/14, Resident #26 became acutely ill with abdominal pain, nausea and vomiting, and a firm abdomen. The resident was sent to the emergency room and was diagnosed with [REDACTED]. Review of the hospital Discharge Summary, dated 05/17/14, revealed Resident #26 suffered an abdominal crisis of pain and nausea, and was found to be massively constipated, with a large volume of BM induced by the administration of enemas. Although Resident #26 returned to the facility on [DATE], after being diagnosed and treated for [REDACTED]. Review of the Bowel Elimination Record, dated 05/14, revealed there was no documentation on the Record until 05/22/14, five (5) days after the resident returned to the facility from the hospital. Resident #16 was care planned for the potential for constipation and had a goal to produce an adequate bowel movement at least every three (3) days. However, review of the Elimination Report revealed Resident #16 had a period of no documented bowel movements between the dates of 06/15/14 through 06/22/14 and 07/14/14 through 07/19/14 with no documented evidence the nurses recognized Resident #16 had not had a bowel movement for greater than three (3) days and no documented evidence of intervention as per the care plan. In addition, newly admitted Resident #35 was care planned for alteration in comfort/pain, related to a [DIAGNOSES REDACTED]. However, the resident requested his/her pain medication on 07/02/14 at 8:00 PM but did not receive the medication until 07/03/14 at 3:05 PM. The findings include: Interview with the Director of Nursing (DON), on 07/27/14 at 12:42 PM, revealed the facility had no written policy related to staff following the Comprehensive Care Plan or the Interim Care Plan. However, she stated it was the expectation of the facility for staff to follow each resident's written plan of care. 1. Medical record review revealed the facility admitted Resident #17 on 03/29/13 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #17 to have a Brief Interview for Mental Status score of fifteen (15), which indicated the resident was cognitively intact. Continued review of the MDS revealed Resident #17 was assessed as always incontinent of urine and frequently incontinent of BM, and the resident required two (2) staff for extensive assistance with toileting. Review of Resident #17's Comprehensive Care Plan, dated 04/08/13, revealed the resident was care planned to be at risk for bowel elimination problems due to the [DIAGNOSES REDACTED]. Continued review revealed the goal was for Resident #17 to have a BM at least once every three (3) days. Further review of the care plan revealed the interventions included monitoring Resident #17's bowel elimination status, reporting any bowel status changes to the Physician, and administering and monitoring the effectiveness of bowel medications. Review of Resident #17's July 2014 computerized Elimination Report revealed no documented evidence, from 07/15/14 through 07/19/14, of the resident having had a BM. Review of the July 2014 Physicians Orders revealed Resident #17 had the stool softener, [MEDICATION NAME] Sodium 100 milligram (mg) by mouth every other day, ordered for a [DIAGNOSES REDACTED].#17 had four (4) PRN bowel medications ordered which included two (2) different mini-enemas, Senna 8.6 mg two (2) tablets by mouth daily PRN (laxative), and Polyethylene [MEDICATION NAME] 17 grams (gm) in 240 ml (milliliters) of fluid by mouth daily PRN (laxative). Review of the July 2014 Medication Administration Record [REDACTED]. Review revealed the PRN medication, Senna 8.6 mg two (2) tablets by mouth was administered on 07/19/14 at 10:02 PM and was noted to have had a minimal effect. Further review of the MAR indicated [REDACTED]. Record review revealed the Nurse's Notes dated 07/15/14 through 07/18/14 contained no documented evidence of Resident #17 experienced a BM. In addition, there was no documented evidence the resident's bowel elimination status was monitored, or any of the four (4) PRN bowel medications were administered as directed by the care plan. Continued review of the Nurses Notes, dated 07/19/14 at 9:50 PM, revealed the Physician ordered Milk of Magnesia (MOM) thirty (30) ml PRN (laxative) for constipation and the medication was administered. However, continued review revealed no documented evidence the effectiveness of the MOM was monitored as per the care plan. Review of the Nurses Notes, dated 07/20/14 at 10:20 AM, revealed Resident #17 complained of abdominal pain and PRN bowel medications were administered as ordered. Continued review of the 07/20/14 10:20 AM Nurses Note revealed the resident vomited bright red blood two (2) times, the Physician was notified and an order was received to send the resident to the ER. The nurse also documented she had assessed Resident #17's abdomen to have positive bowel sounds in all four (4) quadrants, and noted the resident was complaining of right upper quadrant abdominal tenderness. Furthermore, the nurse noted emergency medical services (EMS) were notified to transport Resident #17 to the ER. Review of the hospital ER record revealed Resident #17's arrival time at theER on [DATE] was 11:24 AM. Review of the ER Physician's documentation revealed the resident had quiet bowel sounds and was experiencing right upper quadrant abdominal pain. Continued review revealed the ER Physician ordered diagnostic testing which included a computerized tomography (CT) scan of the pelvis and abdomen. Review of the results of the CT scan revealed Resident #17 was severely impacted. Further review of the ER record revealed Resident #17 received an enema, was manually disimpacted with good results, and was discharged back to the facility. Interview with Resident #17, on 07/25/14 at 10:50 AM, revealed the resident had problems related to constipation due to his/her immobility and history [MEDICAL CONDITION]. Resident #17 reported having about four (4) different medications ordered for constipation. Per interview, Resident #17 stated he/she had been constipated and had not experienced a BM the week before being sent to the ER. Resident #17 stated he/she was not positive, but thought nurses had given him/her bowel medications before going to the ER. Further interview with Resident #17 revealed he/she had been so sick when sent to the ER. Interview with State Registered Nursing Assistant (SRNA) #6, on 07/25/14 at 2:48 PM, SRNA #8 on 07/25/14 at 3:05 PM, SRNA #31 on 07/29/14 at 3:20 PM, and SRNAs #18 and #20 on 07/30/14 at 2:55 PM, revealed all had cared for Resident #17 prior to him/her being sent to the ER and were aware the resident had a history of [REDACTED].#6, SRNA #31 and SRNA #20, Resident #17 had complained of constipation prior to going out to the hospital on [DATE]. SRNA #6 stated Resident #17 reported to her the nurses were giving him/her stuff for the constipation. SRNA #31 stated Resident #17 had complained of constipation prior to being sent to theER on [DATE], and he had reported Resident #17's complaints to the nurses who informed him they had given what they could. SRNA #20 stated Resident #17 had complained of constipation prior to going to the ER, and this was reported to the nurses. Interview with Licensed Practical Nurse (LPN) #10 on 07/29/14 at 3:55 PM, revealed she indicated she had cared for Resident #17 in July 2014 during the timeframe before the resident was sent to the ER. LPN #10 indicated she could not recall if the resident complaints of constipation prior to going to theER on [DATE], or if she had performed an abdominal assessment on the resident during the week prior to him/her going to the ER. She stated Resident #17 should never go more than three (3) days without a BM due to his/her history of constipation. Continued interview with LPN #10 revealed she thought Resident #17's Comprehensive Care Plan was located in his/her chart; however, after looking through the resident's medical record, she stated she did not know where the care plan was located and would have to ask another nurse. She reported she had never seen Resident #17's Comprehensive Care Plan, and indicated she was not aware of the problems or interventions located in it. Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she thought she had cared for Resident #17 during the 07/15/14 through 07/20/14 timeframe. She stated she could not remember if she had performed an assessment of Resident #17's abdomen prior to him/her being sent to theER on [DATE], and indicated she also could not recall if Resident #17 had complained of constipation during the week prior to being sent to the ER. She stated Resident #17 could tell staff if he/she was constipated as the resident was alert and oriented. She further stated Resident #17 had a history of [REDACTED]. Continued interview revealed LPN #8 was not aware if Resident #17 was care planned for constipation, or if interventions were in place to prevent it. 2. Review of the medical record revealed the facility admitted Resident #32 on 05/24/13 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14), which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility

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F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 19) assessed Resident #32 to require extensive assistance of two (2) staff for toileting, and to be frequently incontinent of urine and always continent of bowels. Review of Resident #32's Comprehensive Care Plan, revised June 2014, revealed the resident was care planned for a risk for bowel elimination problems due to decreased mobility and [MEDICAL CONDITION]. Review of the care plan for bowel elimination revealed a goal for the resident to have a BM as least once every three (3) days. Continued review of the care plan revealed interventions included reporting changes in bowel status to the Physician, monitoring the resident's bowel elimination status, and administering and monitoring the effectiveness of bowel medications. Review of the June 2014 Elimination Report for Resident #32, revealed three (3) periods of time with no documented evidence the resident had a BM: 06/25/14 through 07/01/14; 07/03/14 through 07/08/14; and 07/14/14 through 07/18/14. Review of the June 2014 physician's orders [REDACTED]. Review of the MAR for June 2014 and July 2014 revealed the PRN MOM was administered on 06/30/14, the sixth day of no documented BM. Additional review of the MAR indicated [REDACTED]. Review of the Nurse's Notes from 06/25/14 through 07/18/14 revealed no documented evidence an abdominal assessment was performed of Resident #32, and no documented evidence PRN bowel medications were administered as per the care plan during the three (3) episodes of no documented BM for a period greater than three (3) days. Interview with Resident #32, on 07/31/14 at 6:25 PM, revealed sometimes he/she would go for three (3) or four (4) days or longer with no BMs. Resident #32 stated he/she thought the nurses gave him/her something for his/her bowels; however, the resident was not sure what was given. Interview with the Advanced Practice Registered Nurse (APRN), on 07/31/14 at 9:55 PM, revealed she was one of Resident #17's primary healthcare providers. Continued interview revealed the resident had a history of [REDACTED]. Interview with Licensed Practical Nurse (LPN) #10, on 07/29/14 at 3:55 PM, revealed she had cared for Resident #32 in June and July 2014. LPN #10 indicated she could not recall if the resident complained of constipation from 06/25/14 through 07/18/14, or if she had performed an abdominal assessment on the resident during that timeframe. She stated she had never seen Resident #32's Comprehensive Care Plans, and indicated she was not aware of the problems or interventions located on it. Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she thought she had cared for Resident #32 during June and July 2014. She indicated she could not remember if she had performed an assessment of Resident #32's abdomen, or if Resident #17 had complained of constipation from 06/25/14 through 07/18/14. She indicated she was not aware if Resident #32 was care planned for constipation or if there were interventions in place to prevent it. 3. Review of the clinical record revealed the facility admitted Resident #26 on 07/23/12 with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed the resident as having a BIMS score of thirteen (13) which indicated the resident was not cognitively impaired. Further review revealed the facility assessed the resident to require the extensive assist of two (2) staff for bed mobility, transfers, and toileting. In addition, the resident was assessed as frequently incontinent of bowel and bladder. Review of Resident #26's Comprehensive Plan of Care, revised November 2013, revealed the resident had the potential for constipation related to decreased physical function and a [DIAGNOSES REDACTED]. The goal stated the resident would produce adequate bowel movements at least every three (3) days. The interventions included: encourage direct care staff to record BMs accurately, administer medications as ordered, and routinely review BM records to determine any necessary interventions. Review of the Nurses Notes for 05/15/14 revealed Resident #26 became acutely ill with abdominal pain, nausea and vomiting, and a firm abdomen. The resident was sent to the ER per the physician's orders [REDACTED]. Review of the hospital Discharge Summary, dated 05/17/14, revealed Resident #26 suffered an abdominal crisis of pain and nausea, and was found to be massively constipated, with a large volume of BM induced by the administration of enemas. Although Resident #26 returned to the facility on [DATE], after being diagnosed and treated for [REDACTED]. Review of the Bowel Elimination Record, dated 05/14, revealed there was no documentation on the Record until 05/22/14, five (5) days after the resident returned to the facility from the hospital. However, review of the Nurses Notes, dated 05/21/14 at 1:00 AM, revealed Resident #26 had several loose stools. Interview with RN #4/Unit Manager (UM) for the South Unit, on 07/29/14 at 5:17 PM, revealed upon return to the facility from the hospital, the facility failed to re-enter Resident #26 into the computer system, and no documentation was completed related to the resident's bowel elimination. Further interview revealed the UM was not aware anyone was monitoring daily to ensure staff was documenting each shift if a resident had a BM. Interview with the Director of Nursing (DON), on 07/31/14 at 8:05 PM, revealed the resident would not have shown up on the Report which was run from the computer daily to identify those residents who had no BM in seventy-two hours (72) hours if the resident had not been entered into the computer system on return from the hospital. The DON stated it would be important to closely monitor Resident #26 for bowel elimination after being treated in the hospital for Obstipation. She further stated the Comprehensive Care Plan should have been followed related to ensuring the resident had a BM every three (3) days. Continued interview revealed the nurse assigned to Resident #26's care at any given time was responsible for following the care plan. 4. Record review revealed Resident #16 was admitted by the facility on 02/01/12 with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 06/2014, revealed Resident #16 was care planned for the potential for constipation and had a goal to produce an adequate bowel movement at least every three (3) days. Interventions included: encourage direct care staff to record bowel movements accurately, administer medications if ordered, observe for signs and symptoms of discomfort, and review bowel movement records to determine any necessary interventions. Review of the Elimination Report revealed Resident #16 had a period of no documented bowel movements between the dates of 06/15/14 through 06/22/14. Review of the Nurses Notes for the same period revealed no documented evidence the nurses recognized Resident #16 had not had a bowel movement for greater than three (3) days, contrary to the care planned goal for the resident. Although nursing documentation revealed the resident had abdominal assessments conducted, there was no reference to any PRN medications being administered when there was no BM after three (3) days, and no evidence the bowel record was monitored, according to the care plan. Further review of Resident #16's Elimination Report revealed another period of no documented BM between the dates of 07/14/14 through 07/19/14. Review of the Nurses Notes for the same time period revealed no documented evidence the nursing staff recognized Resident #16 had no BM every three (3) days, as per the stated goal on the Comprehensive Care Plan. In addition, continued review of the Nurses Notes revealed no documented evidence any PRN bowel medications were administered as directed by the care plan. Review of the MAR for June 2014 and July 2014 revealed Resident #16 had no PRN bowel medications ordered or administered between 06/15/14 and 07/19/14. Review of the Physician order [REDACTED]. Interview with LPN #8, on 07/30/14 at 12:50 PM, revealed if a resident did not have a bowel movement for several days she would give the resident a PRN medication on the third day if it were prescribed, or notify the Physician if an order was required. Interview with the DON, on 07/31/14 at 8:05 PM, revealed if Resident #16's Comprehensive Care Plan had a goal for an adequate bowel movement every three (3) days, it was her expectation for the licensed nursing staff to follow the care plan. 5. Medical record review revealed Resident #35 was admitted by the facility on 07/02/14 with [DIAGNOSES REDACTED]. Continued review revealed the resident was admitted at 2:15 PM. Review of the Interim Care Plan, dated 07/02/14, revealed Resident #35 had the identified problem of alteration in comfort/pain. Interventions to manage the resident's pain included the administration of medications as ordered. Further review of the clinical record revealed Resident #35's admission orders [REDACTED]. Review of the Nurses Notes, dated 07/02/14 at 8:00 PM, revealed RN #6 documented Resident #35 was upset because her pain medicine was not available. The nurse documented she notified the Pharmacy and was told the medication would be delivered on the at approximately midnight or 1:00 AM. Continued review revealed the nurse informed the resident the pain medication would be given when it was received from the Pharmacy. Interview with RN #6, on 07/31/14 at 10:05 AM, revealed Resident #35 began asking for pain medication at approximately 8:00 PM on 07/02/14, the day of admission. She stated she contacted the Pharmacy at 8:00 PM on 07/02/14 about the resident's pain medication and was told it would be delivered on the midnight run; however, the medications did not arrive at the facility until 4:00 AM on 07/03/14. At that time, Resident #35 was asleep and the nurse did not awaken the resident to administer the medication. RN #6 further stated the resident was upset and disappointed because he/she had been assured by the hospital staff his/her pain medication would be available at the facility. Further interview revealed RN #6 did not remember if she asked the Pharmacy for a STAT delivery. Continued interview revealed RN #6 did check the emergency box when Resident #35 requested pain medication, but the [MEDICATION NAME] was not stocked at the ordered dose. The nurse acknowledged she did not follow the written plan of care related to managing Resident #16's pain, and should have taken additional steps to secure the medication, including informing the Physician to seek additional orders or a change in dose for the [MEDICATION NAME]. Review of the MAR indicated [REDACTED]. Interview with the Pharmacist, on 07/31/14 at 10:45 AM, revealed Resident #35's admission medication orders were processed by the Pharmacy on 07/02/14 at 6:00 PM, and delivered to the facility on [DATE] at 4:08 AM. He stated the nurses were instructed to use the emergency box at the facility when medications were needed prior to delivery from the Pharmacy. He further stated if the medications were not available in the emergency box, the nurse should contact the Pharmacy and request a STAT delivery. Continued interview revealed the

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 20) Pharmacist could find no documentation to indicate the Pharmacy had been contacted for a STAT delivery for Resident #35 on 07/02/14, although all calls from facilities were logged by the Pharmacy staff when the call came in. Interview with the DON, on 07/31/14 at 3:30 PM, revealed Resident #35's nurse should have notified the Pharmacy for a STAT delivery of the resident's medications. She stated the nurse could take other steps to ensure the resident's care was provided according to the care plan. For example, if the resident's medication was not delivered from the Pharmacy in a timely manner, and was not available in the facility's emergency box, the nurse should call the DON for assistance, and notify the Physician for possible additional orders. Continued interview revealed the DON had the expectation for the nursing staff to follow the care plan Resident #35 was discharged from the facility on 07/09/14, prior to the State Agency survey. An attempt to interview Resident #35 by telephone, on 07/29/14 at 3:30 PM, was unsuccessful.
F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure necessary care and services were provided for residents in accordance with the comprehensive assessment and plan of care related to following the facility's unwritten bowel protocol, and ensuring the availability of prescribed medications, for six (6) of thirty-seven (37) sampled residents (#16, #17, #26, #32, #35, and #36). Interviews with staff revealed the facility's bowel protocol directed if a resident did not have a bowel movement (BM) within three (3) days they were placed on the computerized bowel list which was printed out each day, and were to receive follow-up assessments and PRN (as needed) bowel medications. Resident #17, who had a history of [REDACTED]. A PRN bowel medication was given to the resident late in the evening of 07/19/14, at 10:02 PM, with no documented evidence of results. On 07/20/14, staff administered another PRN bowel medication, and obtained an order for [REDACTED]. At 10:20 AM on 07/20/14, Resident #17 complained of abdominal pain, and began to vomit bright red blood. The Physician was notified and the resident was transported to the hospital emergency room (ER), where he/she was diagnosed with [REDACTED]. In addition, the facility failed to provide documented evidence Residents #32, #16, and #36 had a BM every three (3) days, for periods ranging from five (5) to six (6) days. Additionally, there was no documented evidence the facility followed their protocol related to completing bowel assessments and administering bowel medications as ordered for these residents. Also, although Resident #26 returned to the facility on [DATE] after being diagnosed and treated for [REDACTED]. Review of the Bowel Elimination Record revealed there was no documented BM after the resident returned from the hospital until 05/22/14, five (5) days later. In addition, Resident #35 was admitted on [DATE] at 2:15 PM, and requested pain medication later that evening, at 8:00 PM. However, the medication was not delivered to the facility from the Pharmacy until 4:00 AM in the morning on 07/03/14, and was not administered to Resident #35 until 3:05 PM on 07/03/14. There was no documented evidence the facility assessed and monitored the resident's pain, and no evidence any additional attempts to obtain the resident's medication were made. The findings include: Interview with the Director of Nursing (DON), on 07/27/14 at 12:42 PM, revealed the facility had no written policy related to bowel elimination or a bowel protocol; however, she reported the facility had an unwritten protocol which staff followed. The DON stated a computerized report was generated and printed daily from the Bowel Elimination Reports, and indicated which residents had not had a BM in the past three (3) days, or seventy-two (72) hours. Continued interview revealed the Reports were given to the two (2) Assistant Directors of Nursing (ADONs) in the clinical meeting each morning Monday through Friday, and the Weekend Supervisor obtained the Report on weekends and distributed them to the nurses on each of the facility's two (2) units. The DON stated the nurses assigned to the medication carts were to complete an abdominal assessment on each resident listed on the Report. The assessment included checking for the presence of bowel sounds, and assessing for abdominal distension or firmness. She further stated the nurse was also to assess the residents' hydration status by observing the oral cavity and mucous membranes, skin turgor (elasticity) and fluid intake. Continued interview revealed the nurse could initiate non-medical interventions such as prune juice if that normally worked for the resident, or could administer a PRN laxative or obtain an order for [REDACTED]. She stated the resident would keep appearing on the Report until a BM was documented on the Kiosk (computerized charting program), and the nurses were to continue with the abdominal and hydration assessments and continue to administer other laxatives or call the Physician as needed for additional orders. The DON stated the residents who had not had a BM in seventy-two (72) hours were discussed in the clinical meetings Monday through Friday and the ADONs were to follow up with the nurses and ensure the PRN medications were administered and the assessments were documented. Interview with the Registered Nurse (RN) #4/Assistant DON for the South Unit, on 07/29/14 at 5:17 PM, revealed she was given a list of residents who had not had a BM in three (3) days daily Monday through Friday during the morning clinical meeting. She stated she hung the list at the nurses' station on her unit for reference by the nurses assigned to the medication carts. She explained if a resident had no BM in three (3) days, bowel assessments were to be completed by the nurse, and the nurse was to administer a PRN laxative medication or a non-medicinal intervention such as prune juice or whatever was appropriate for the specific resident. She further stated, if there was no response (no BM) later that day, the next shift was to follow up with another laxative or enema, or call the Physician for orders. Continued interview revealed there was no follow-up monitoring related to whether the laxative was given or if it was effective. However, she stated, about a week ago she started having staff turn the list back to her so she could check to see if a laxative was given and if it was effective for residents with no BM in three (3) days. She stated the Report of residents with no BM in seventy-two (72) hours was taken each morning Monday through Friday to the clinical meeting; however, each resident was not discussed individually, only the list was distributed. 1. Review of Resident #17's medical record revealed the facility admitted the resident on 03/29/13 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #17 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated no cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #17 to always be incontinent of urine and frequently incontinent of BM, and to require extensive assistance of two (2) staff with toileting. Review of Resident #17's Comprehensive Care Plan, dated 04/08/13, revealed the resident was care planned for at risk for bowel elimination problem related to decreased mobility and [MEDICAL CONDITION]. Review of the risk for bowel elimination care plan revealed a goal for Resident #17 to have a regular bowel elimination pattern as evidenced by soft/formed BMs at least once every three (3) days. Continued review of the risk for bowel elimination care plan revealed interventions included: monitoring bowel elimination status; reporting changes in bowel status to the Physician; and administering medications used for bowel elimination problems and monitoring for effectiveness and side effects of the medications. Review of the Physician order [REDACTED].#17 was to receive [MEDICATION NAME] Sodium 100 milligram (mg) by mouth every other day for a [DIAGNOSES REDACTED]. 8.6 mg, two (2) tablets by mouth daily PRN. Review of Resident #17's Elimination Report for July 2014, revealed no documented evidence the resident had a BM from 07/15/14 through 07/20/14, a total of six (6) days. Review of the Nurses Notes from 07/15/14 through 07/18/14, revealed four (4) days of no documented BMs. Further review revealed no documented evidence the unwritten bowel protocol had been implemented for Resident #17 in regards to performance of an abdominal assessment to include whether Resident #17 had positive bowel sounds in all four (4) quadrants, and whether he/she had abdominal distention, or whether the resident's rectal vault was checked digitally for impaction. Continued review revealed no evidence of the administration of PRN bowel medications during that timeframe, although the unwritten protocol was for an abdominal assessment to be completed if the resident had not had a BM in the last three (3) days, and PRN medications were to be administered. Continued review of the Nurses Note dated 07/19/14 at 9:50 PM, revealed an order for [REDACTED]. Further review of the Nurses Notes, dated 07/20/14 at 10:20 AM, revealed the following: Resident #17 complained of abdominal pain and PRN bowel medications were administered as ordered; the resident was drinking warm coffee and vomited bright red blood two (2) times; and the Physician was notified and an order was received to send the resident to the ER. Further review of the Nurses Note revealed the nurse assessed Resident #17 to have positive bowel sounds in all four (4) quadrants, and complaints of tenderness in the right upper abdominal quadrant. Continued review of

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 21) this Note revealed a late entry for 07/19/14 documented within it, which indicated Resident #17 had PRN bowel medications given on 07/19/14 at 9:00 AM and at 6:45 PM. Review of the late entry note revealed the resident was given a PRN enema for complaints of constipation with no results, no stool visible. However, the nurse documented the abdominal assessment as non-tender, non-distended, with bowel sounds present times four (4) quadrants. Review of the July 2014 Medication Administration Record (MAR) revealed the [MEDICATION NAME] Sodium was administered every other day as ordered; however, there was no documented evidence PRN bowel medications were administered from 07/15/14 until 07/19/14 at 10:02 PM when Senna 8.6 mg two (2) tablets by mouth was given. Continued review of the MAR revealed the Senna laxative medication was again administered on 07/20/14 at 11:27 AM, and MOM 30 ml was administered at the same time. Review of the MAR, As Needed Administrations Report revealed: the Senna laxative was administered on 07/19/14 at 10:02 PM, and the effectiveness noted to be with minimal effect; the Senna and the MOM were noted to have been administered on 07/20/14 at 11:27 AM with no effect. Further review of the MAR and the As Needed Administrations Report revealed no documented evidence PRN bowel medications were administered on 07/19/14 at 9:00 AM, or on 07/19/14 at 6:45 PM, as indicated by the nurse's late entry note for that date. Review of the hospital ER record revealed Resident #17 arrived at the ER at 11:24 AM on 07/20/14, and was triaged at 11:26 AM by an ER Registered Nurse, who noted the resident's complained of nausea, vomiting and abdominal pain, and reported having vomited bright red blood. Review of the ER Physician's History and Physical revealed the resident had right upper quadrant abdominal pain and bowel sounds were noted as quiet. Review of the ER physician's orders [REDACTED]. Review of the Radiology Results of the CT scan revealed fecal impaction noted severely involving the rectal vault, with the conclusion noted as severe fecal impaction rectal vault. Continued review of the ER record revealed the Physician noted an enema was administered and manual disimpaction (removal of BM) with good results. Further review of the ER record revealed Resident #17 was discharged back to the facility at 4:10 PM in stable condition. Interview with Resident #17, on 07/25/14 at 10:50 AM, revealed the resident had trouble with constipation because of his/[MEDICAL CONDITION] and immobility. Resident #17 reported he/she had approximately four (4) poop medicines ordered. Continued interview revealed prior to being sent to theER on [DATE], Resident #17 was constipated and had not had a BM all the week before. Resident #17 believed staff had given him/her bowel medications before going to the ER; however, the resident was not positive of this. Resident #17 reported having been so sick at the time of transfer to the ER. Interview with State Registered Nursing Assistant (SRNA) #6, on 07/25/14 at 2:48 PM, and SRNA #8 at 3:05 PM, revealed both had cared for Resident #17. They stated they documented residents' BMs in the Kiosk, computer system, and if any residents had not had a documented BM in three (3) days the nurses let them know, from the list, if they had given the residents bowel medications, and to watch those residents for a BM. SRNA #6 stated Resident #17 had complained of constipation prior to going out to the hospital on [DATE]. SRNA #6 reported Resident #17 had told her the nurses were giving him/her stuff for the constipation. She stated she could not recall if Resident #17 had a BM the week before; however, she indicated if the resident had a BM it should be documented in the Kiosk. Interview with SRNA #31, on 07/29/14 at 3:20 PM, revealed he had cared for Resident #17 before. SRNA #31 stated the facility's process was if a resident did not have a BM in three (3) days the nurses would give the resident whatever constipation medication they had ordered. Continued interview revealed the nurses had a bowel list, and alerted the SRNAs to which residents were on it. He stated the SRNAs generally cared for the same residents from day to day, so they knew how long a resident went without a BM, and the nurses monitored the resident. SRNA #31 reported residents' BMs were documented in the Kiosk. Per interview, SRNA #31 stated Resident #17 usually just went a few days without a BM, and it was not usually a week. Further interview with SRNA #31 revealed Resident #17 had complained of constipation a couple of times before going to theER on [DATE], and he reported this information to the nurses who told him they had given what they could. Interview, on 07/30/14 at 2:55 PM, with SRNA #18 and SRNA #20, revealed they had cared for Resident #17 before, and were aware he/she had problems with constipation. SRNA #20 stated Resident #17 had complained to the SRNAs of being constipated before being sent out to the ER, and the SRNAs had told the nurses. The SRNAs stated they thought the nurse had given Resident #17 enemas, but they could not be sure. Interview with LPN #1, on 07/25/14 at 3:11 PM, revealed the facility did not have a written bowel protocol; however, there was a process in place whereby every Monday through Friday a list was printed from the Kiosk (computer) for residents who had not had a BM in seventy-two (72) hours, and the list was given to the nurses on the medication carts. LPN #1 stated when she received a list of residents without BMs, she talked to the SRNAs and verified the resident had not had a BM. She stated sometimes the SRNAs didn't get everything documented in the Kiosk as they should, therefore the Kiosk was not always accurate. Continued interview with LPN #1 revealed after verifying there had been no BMs, she performed an abdominal assessment of the resident, listening for bowel sounds and looking for distention and signs and symptoms of constipation. LPN #1 stated the nurses were responsible for monitoring to ensure residents had BMs. Therefore, LPN #1 stated, if a resident had not had a BM in seventy-two (72) hours, after assessment the nurse should give a PRN bowel medication; if the resident did not have PRN medications ordered they were to notify the Physician for orders. Interview with LPN #10, on 07/29/14 at 3:55 PM, revealed she had cared for Resident #17 before, and she indicated she thought she had cared for the resident during the 07/15/14 through 07/20/14 timeframe. She stated the facility had a bowel protocol where a bowel care list of residents was printed out each morning for residents who had not had a BM in seventy-two (72) hours. LPN #10 stated the list was brought to the nurses by RN #4/ADON or by the Director of Nursing (DON); and, on weekends the Weekend Supervisor obtained the list to give to the nurses. Continued interview revealed after receiving the list, the nurses asked the SRNAs about the resident's BMs, and if the resident was alert and oriented, she would ask the resident if they had a BM. She further stated the nurse assessed the resident to check for bowel sounds and distention, which would be documented in the resident's medical record. LPN #10 stated if the resident and SRNAs reported no BM, the nurse would administer PRN bowel medications. According to LPN #10, if the resident did not experience a BM before the end of the nurse's shift, who administered the PRN bowel medication, the resident's name and information was passed along to the oncoming shift and placed on the facility's twenty-four (24) hour report for follow-up. Further interview with LPN #10 revealed Resident #17 had a history of [REDACTED]. She stated Resident #17 should never go more than three (3) days without a BM due to his/her history. She indicated she could not recall if Resident #17 had complained of constipation, or if she had performed an abdominal assessment of the resident during the week prior to the resident going to theER on [DATE]. Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she had cared for Resident #17, and indicated she thought she had cared for the resident during the 07/15/14 through 07/20/14 timeframe. Continued interview with LPN #8 revealed the facility had a bowel list which was printed each day for residents who had no documented BM for seventy-two (72) hours. She stated RN #4/ADON gave the list to the nurses assigned to the medication carts so they could determine which of the residents they were responsible for, and check further to see if the resident really had not had a BM. LPN #8 stated if the resident had not had a BM, the nurse would perform a bowel assessment and administer a PRN bowel medication. She reported residents stayed on the bowel list until they had a BM, and if a PRN was administered with no results the Physician was notified for additional orders. LPN #8 stated she was aware of Resident #17's history of constipation, and knew she had several different PRN medications for the constipation. Further interview revealed LPN #8 could not recall if she had assessed Resident #17's abdomen during the week before he/she went to the ER, and could not recall if Resident #17 had complained of constipation before being sent out to theER on [DATE]. She stated Resident #17 was alert and oriented and could tell staff if he/she was constipated. LPN #8 stated when Resident #17 went out to the ER, he/she was found to be severely impacted. The LPN indicated Resident #17 should never go greater than three (3) days without a BM related to his/her history of constipation. Interview on 07/31/14 at 9:55 PM, with the Advanced Practice Registered Nurse (APRN), who was Resident #17's primary healthcare provider, revealed she saw the resident at least one (1) time per month, unless the resident had an acute problem in which case the APRN saw the resident more often. The APRN stated Resident #17 had a history of [REDACTED]. She explained the resident's main problem was slow peristalsis (a series of muscle contractions which occur in the digestive tract to move food through the digestive system). The APRN stated as Resident #17's peristalsis was so slow, the resident needed a lot of laxatives. She further stated she had ordered several PRN bowel medications for Resident #17, and if the resident did not have a BM for three (3) days, he/she should be given a PRN bowel medication. Continued interview with the APRN revealed the facility had a bowel list of residents who had not had a BM in three (3) days, and the healthcare provider was supposed to be notified of this information. She stated if she had been notified of Resident #17 not having a BM for greater than three (3) days, she would have told the nurses to check the resident digitally and ask if the resident wanted a suppository. The APRN stated if the suppository didn't work, she would have had the nurses give Resident #17 an enema. Further interview revealed she did not like for any of her residents to go more than three (3) days without a BM, and if the resident went that long they would need to take something for their bowels. She stated she had never been made aware of Resident #17 having been severely

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 22) impacted when he/she went to theER on [DATE]. She reported the primary care Physician may have known about the [DIAGNOSES REDACTED]. 2. Review of the medical record revealed the facility admitted Resident #32 on 05/24/13 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14), indicating the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #32 to be frequently incontinent of urine and always continent of bowels, and to require extensive physical assistance of two (2) staff with toileting. Review of Resident #32's Comprehensive Care Plan, dated 06/06/13, revealed the resident was care planned for at risk for bowel elimination problem related to decreased mobility and [MEDICAL CONDITION]. Continued review revealed a goal for Resident #32 to have a regular bowel elimination pattern as evidenced by soft/formed BMs at least once every three (3) days. Continued review of the risk for bowel elimination care plan revealed interventions included: monitor bowel elimination status; report changes in bowel status to the Physician; check and remove hard stool PRN; and administer and monitor effectiveness and side effects of medications used for bowel elimination problems. Further review of Resident #32's Comprehensive Care Plan, revised June 2014, revealed the resident was care planned for an ADL (activities of daily living) self care deficit related to the resident's diagnoses, including a History of Stroke with Right [MEDICAL CONDITION]. Review of the June 2014 Physicians Orders revealed Resident #32 had [MEDICATION NAME] Sodium 100 milligram (mg) by mouth twice daily for a [DIAGNOSES REDACTED]. Review of Resident #32's Elimination Report for June 2014, revealed no documented evidence the resident had a BM from from 06/25/14 through 07/01/14, a total of seven (7) days, from 07/03/14 through 07/08/14, a total of six (6) days, or from 07/14/14 through 07/18/14, a total of five (5) days. Review of the June and July 2014 MAR revealed the scheduled [MEDICATION NAME] Sodium was administered as ordered. However, continued review of the MAR revealed the following: for the 06/25/14 through 07/01/14 timeframe, the PRN MOM thirty (30) ml was administered on 06/30/14, the sixth day of no documented BM; and for the periods from 07/03/14 through 07/08/14, and 07/14/14 through 07/18/14, there was no documented evidence a PRN bowel medication was administered. Review of the June and July MAR, As Needed Administrations Report revealed the MOM was administered on 06/30/14 at 9:47 AM, with the effectiveness documented as with good effect at 10:59 AM, even though the Elimination Report had no documented evidence of a BM on that date. Further review of the Report revealed no documented evidence a PRN bowel medication was administered from 07/03/14 through 07/21/14. Review of the Nurses Notes from 06/25/14 through 07/18/14 revealed no documented evidence the unwritten bowel protocol was implemented for Resident #32 related to the performance of an abdominal assessment after the resident went three (3) days without a BM, even though staff interviews revealed the unwritten protocol directed staff to complete an abdominal assessment when there was no BM in three (3) days. Interview with Resident #32, on 07/31/14 at 6:25 PM, revealed the resident sometimes went three (3) or four (4) days, or longer, with no BM. Continued interview revealed Resident #32 thought he/she got something for his/her bowels, but was not sure what it was. Further interview revealed Resident #32 had hemorrhoids which were painful at times. Interview with LPN #10, on 07/29/14 at 4:17 PM, revealed she had cared for Resident #32 before, and she thought she had cared for the resident between 06/25/14 and 07/18/14. She stated the facility's unwritten bowel protocol should have been followed for Resident #32. Continued interview revealed LPN #10 could not recall if Resident #32 had been on the bowel care list, printed each morning for residents who had not had a BM in seventy-two (72) hours. Further interview revealed she could not recall if she had assessed the resident's abdomen during that timeframe. She stated the resident should not go longer than three (3) days without a BM. Interview with LPN #8, on 07/30/14 at 2:40 PM, revealed she had cared for Resident #32, and thought she had cared for the resident from 06/25/14 through 07/18/14. Continued interview with LPN #8 revealed she could not recall if Resident #32 was on the bowel list during that timeframe, and she did not remember assessing the resident's abdomen during that time. Interview, on 07/31/14 at 9:55 PM, with the APRN who provided healthcare services for Resident #32, revealed if the resident was on the bowel list of residents who had not had a BM in three (3) days, he/she would require a PRN bowel medication. The APRN stated she did not like her residents to go longer than that without a BM. 3. Review of the medical record revealed the facility admitted Resident #26 on 07/23/12 with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed the resident as having a BIMS score of thirteen (13), which indicated the resident was cognitively intact. Further review of the MDS revealed the facility assessed the resident as requiring the extensive assist of two (2) staff for bed mobility, transfers, and toileting. In addition, the facility assessed the resident as being frequently incontinent of bowel and bladder. Review of Resident #26's Comprehensive Plan of Care, revised 11/13, revealed the resident had the potential for constipation with a goal stating the resident would produce adequate bowel movements at least every three (3) days. There were several interventions including: encourage direct care staff to record BMs accurately, administer medications as ordered, and routinely review BM records to determine any necessary interventions. Review of the Bowel Elimination Record, dated 05/14, revealed Resident #26 had a BM documented on 05/12/14 as large and soft; and, on 05/15/14 as medium and soft at 2:42 PM. Review of the Nurses Notes dated 05/15/14, revealed Resident #26 became acutely ill at 6:45 PM, when the resident exhibited nausea and vomiting. At 8:30 PM, the resident again vomited. At 11:50 PM, the resident had increased vomiting with a new onset of a firm abdomen and a decrease in bowel sounds. Continued review of the Nurses Notes revealed throughout the evening of 05/15/14, the nurse monitored the resident's condition, assessed the abdomen, was in contact with the Physician and the APRN, and administered medications based on new orders as they were received. At 11:50 PM, Resident #26 was sent to the ER per the physician's orders [REDACTED]. Despite the resident's history of adequate BMs in the previous three (3) days, a review of the Hospital Discharge Summary dated 05/17/14 revealed Resident #26 was admitted with a [DIAGNOSES REDACTED]. Continued review revealed the resident had vomiting, an abdominal crisis of pain and nausea, and was found to be massively constipated. Further review revealed a large volume of stool was induced via enemas and a large amount of material was pulled via the nasogastric tube (a tube which is passed through the nose and into the stomach). Review of the report for the CT (Computerized Tomography) Scan of the Abdomen and Pelvis performed on 05/16/14 revealed the rectum was distended with stool measuring eight (8) centimeters diameter, and the stomach was distended. Further review of the Summary revealed mild Pneumonia was identified and the resident was started on [MEDICATION NAME] (antibiotic medication). Although Resident #26 returned to the facility on [DATE], after being diagnosed and treated for [REDACTED]. Review of the Bowel Elimination Record revealed there was no documentation until 05/22/14, five (5) days later after the resident returned to the facility. However, review of the Nurses Notes, dated 05/21/14 at 1:00 AM, revealed the resident had several loose stools. Interview with RN #4/Unit Manager (UM) for the South Unit where Resident #26 resided, on 07/29/14 at 5:17 PM, and review of the Elimination Report with the UM, revealed there was no documentation to indicate the resident did, or did not, have a BM on any shift from 05/17/14 through 05/20/14. The UM explained, since there was no documentation at all, it looked as though the resident was not put back in the system prior to 5/21/14; therefore, the SRNAs were not able to document anything related to the resident's BMs or lack thereof. The UM stated when a resident was transferred out of the building, they were taken out of the main computer system of the facility, and when the resident returned they were to be entered back into the system. She further stated the floor nurses, the DON, the MDS Coordinators and a few others, including herself, had the ability to take residents out of the system and enter them back into the system. Continued interview revealed she had no knowledge anyone was monitoring daily to ensure staff were documenting on each shift if a resident had a BM. She further stated the computer gave a percentage at the end of each shift to show how much required documentation had been completed, and indicated which questions had not been answered. The UM stated she looked at this daily Monday through Friday and reminded the SRNAs to document in the Kiosk about 2:30 PM; however, she was unsure sure if the nurses on the second and third shifts, and on the weekends, knew how to do this. Interview with the DON, on 07/31/14 at 8:05 PM, revealed the nurses on the unit took the residents out of the computer system when they were transferred out of the facility, and the nurse assigned to the resident upon the resident's return was to enter the resident back into the system. She stated there was no check system she was aware of to ensure residents were put back in the system when they returned to the facility. Continued interview revealed the resident would not show up o
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 23) to ensure a resident with a catheter received the appropriate care and services to prevent infections to the extent possible for one (1) of thirty-seven (37) sampled residents (Resident #6). Observation of perineal care for Resident #6 revealed the resident's perineal area, including the Foley indwelling catheter, was covered with bowel movement. The staff cleaned the bowel movement with wet wipes from the skin of the perineal area, then changed the wet wipes to clean the Foley catheter tubing, which was also covered with stool. In cleaning the tubing the staff cleaned the tubing towards the vaginal area. The findings include: Review of the facility's Foley Catheter Care Policy, effective December 2010, revealed the purpose of catheter care was to prevent the spreading of bacteria from the perineal area and external catheter into the bladder, thus avoiding a possible urinary tract infection. Continued review revealed perineal care was to be performed twice daily, and consisted of washing the perineal area and the catheter with clean, warm, soapy water, followed by rinsing of the areas. Further review of the policy revealed it did not specify in which direction the catheter was to be cleaned. Review of Resident #6's medical record revealed [DIAGNOSES REDACTED]. ESBL and VRE are bacteria which are resistant to multiple drugs. Review of the medical record revealed laboratory data indicating a stool specimen for [MEDICAL CONDITION] was collected on 06/10/14, and reported on 06/11/14 as [MEDICAL CONDITION] positive. Continued review of the medical record revealed a new physician's orders [REDACTED]. Continued review revealed a new physician's orders [REDACTED]. Further review revealed a physician's orders [REDACTED]. Further review of the medical record revealed laboratory data indicated a urine specimen was collected on 06/27/14, and reported on 06/29/14 as a E-coli ESBL and [MEDICATION NAME] Faecium VRE UTI. Further review revealed a physician's orders [REDACTED]. Observation of Resident #6's room, on 07/02/14 at 1:50 PM, revealed signage located outside the room to the right of the the door stating, See nurse before entering, contact isolation. In addition, observation revealed a plastic bin containing gowns, gloves and shoe covers (Personal Protective Equipment, or PPE) was located beside the door outside of the resident's room. Continued observation revealed State Registered Nursing Assistant (SRNA) #16 and SRNA #17 were observed to don their gowns, shoe covers and gloves prior to entering Resident #6's room. After donning the PPE, the SRNAs entered the room to provide incontinence care for Resident #6 and to weigh the resident. Observation of the Foley catheter care revealed SRNA #17 cleansed stool from the perineal area, changed her wet wipe and proceeded to cleanse the catheter tubing, which was covered with bowel movement, in an upwards motion toward the vaginal area. Interview with SRNA #17, on 07/02/14 at 2:45 PM, revealed she knew she was to clean the catheter from the vaginal area down towards the urinary drainage bag; however, she had inadvertently cleaned the wrong way in an attempt to clean up the stool. She stated she probably should have washed her hands and changed gloves after cleansing the perineal area as there was noticeable stool in that area, before cleaning the catheter. Interview with the Infection Control Nurse (ICN), on 07/03/14 at 4:30 PM, revealed staff were to wash their hands and use new gloves before performing catheter care. The ICN stated staff should clean catheter tubing from the vaginal area out, toward the drainage bag. She stated there were no recent inservices related to Foley catheter care; however, staff did receive inservices related to this on new hire orientation and yearly. She stated she randomly observed and audited catheter care and incontinence care, and if she saw a problem she would stop staff right then and correct them.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on observation, interview, record review, and Fire Emergency Plan and Evacuation Plan review, during the 07/03/14 survey, it was determined the facility failed to have an effective system to ensure the residents' environment remained as free of accidental hazards as possible. The facility failed to ensure a safe path to a public way for three (3) of the facility's eight (8) exits, which the facility detailed as fire evacuation exits. On 06/24/14, the facility began construction by removing the concrete pavement outside the Northwest hallway exit and the Dining room exit, and on 06/27/14 the Southwest exit door had pavement removed, affecting the safe path to a public way. Observation on 06/30/14 revealed the fire exit located at the end of the Northwest hallway had a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar (common steel bar used in construction to reinforce concrete); the fire exit located at the Dining room exit had a concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar; and, the Southwest hallway had a ramp which led to a four and a half (4.5) inch drop off with gravel. All three (3) of the fire exits remained accessible with no signage posted at the exit doors to alert residents, staff, and visitors these exits were not accessible due to the construction. There was a total of thirty (30) beds on the Northwest hallway and thirty (30) beds on the Southwest hallway which could have potentially affected sixty (60) of the facility's one hundred and twenty-four (124) residents in the event of an emergency evacuation. The facility's failure to ensure the residents' environment remained as free of accidental hazards as was possible was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 06/30/14, and was determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure the resident's environment remains as free of accidental hazards as possible; and each resident receives adequate supervision to prevent accidents. The findings include: Review of the facility's, Disaster Preparedness Manual, dated January 2005, revealed the fire safety procedure plan, stated in preparing for an evacuation after the fire alarm was sounded, staff was to first check the primary exit route. If it was clear and safe, they were to use that exit if evacuation was ordered. Review of the facility's, Fire Safety Procedures Orientation Training, undated, revealed under the evacuation section, staff was to first check the primary exit route, if it was clear and safe, use that exit if evacuation was ordered. Review of the facility's Map on 06/30/14 at 5:15 PM, posted in the dining room, revealed arrows leading from the dining room to the outside exit as an exit route from the dining room. However, observation on 06/30/14 at 5:15 PM, of the Dining room fire exit door revealed a concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar (common steel bar used widely in construction to reinforce concrete). Review of the facility's North Nursing Department Fire Emergency Guidelines revealed staff was to check the primary exit route, if blocked use the secondary route. Continued review revealed staff were to report to the grassy area south of the parking lot on the south side of the building, and the sidewalk in front of the building. Review of the facility's Map on 06/30/14 at 5:20 PM, posted across from the nurse's station on the north unit, revealed an exit route for the Northwest hallway with arrows pointing towards the exit door at the end of the Northwest hallway leading outside. However, observation on 06/30/14 at 5:20 PM revealed the fire exit at the end of the Northwest hallway had a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar. Review of the facility's, South Nursing Department Fire Emergency Guidelines, undated, revealed staff was to check the primary exit route, if blocked use the secondary route. Review revealed staff were to report to the grassy area south of the parking lot on the south side of the building, and the sidewalk in front of the building. Review of the facility's Map on 06/30/14 at 5:24 PM, posted across from the nurse's station on the south unit, revealed an exit route for the Southwest hallway with arrows pointing towards the exit door at the end of the Southwest hallway leading outside. However, observation on 06/30/14 at 5:24 PM revealed the fire exit door at the end of the Southwest hallway had a ramp which led to a four and a half (4.5) inch drop off with gravel and rocky uneven surface. Further observation on 06/30/14 at 5:15 PM, 5:20 PM and 5:25 PM revealed there was no signs posted at the Southwest, Northwest, and Dining room exits to alert staff, residents, and visitors these exits were not accessible due to the construction. Interview with the Director of Plant Operations, on 06/30/14 at 2:20 PM, revealed construction began on 06/24/14 with the removal of the concrete pavement outside of the Northwest Hallway and the Dining room exit and on 06/27/14 the concrete pavement was removed outside the Southwest exit door. Continued interview revealed these three (3) exits were not safely accessible in case of an emergency evacuation. Observation of the Southwest hallway exit door, at the time of the interview, revealed the door was access-controlled with magnetic locks and could be released with a manual

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 24) release device and was operational. Further observation revealed when the green button by the door was pushed, a beeping noise would start and the door would disengage and could be opened within fifteen (15) seconds. Observation on 06/30/14 at 5:15 PM of the dining room fire exit door and at 5:20 PM of the Northeast hallway fire exit doors revealed when the green button by the door was pushed, a beeping noise would start and the door would disengage and could be opened within fifteen (15) seconds. Interview with State Registered Nursing Assistant (SRNA) #1, on 06/30/14 at 3:16 PM, revealed she would have used the Northwest, Southwest, and dining room exits to the outside if an emergency arose which required residents to be evacuated. She stated she was aware of construction going on; however, as far as she knew these exits were not affected. Interview with Housekeeper #1, on 06/30/14 at 3:20 PM, revealed she would use the Northwest, Southwest, and dining room exits to the outside in the case of an emergency evacuation because she had not been told she could not use the exits. Interview, on 06/30/14 at 5:01 PM, with the Social Service Director (SSD) revealed she had sent out a letter to inform families of the construction; however, she did not know the date construction was to start at the time she sent the letter. She viewed the Northwest, Southwest, and dining room exits and stated the residents would not be able to exit these exits due to construction, and this was a safety concern. Review of the letter sent to families by the SSD, revealed a date of 02/19/14, which detailed the renovation at the facility would include fresh paint, flooring, furniture, an expanded gym and the addition of private rooms. However, there was no documented evidence the letter addressed any construction taking place outside the building. Interview, on 06/30/14, at 5:15 PM, with Licensed Practical Nurse (LPN) #4 revealed was not aware these exits could not be used until that day, 06/30/14. Interview, on 06/30/14 at 5:17 PM, with the second shift Supervisor/Registered Nurse (RN) #5 revealed on 06/27/14 she was told not to use the exits to the back of the building, but she thought construction had already began at that time. She stated she did not formally inservice staff not to use those exits; however, did verbally tell some of the staff. Interview, on 06/30/14 at 5:30 PM, with Housekeeper #2 revealed his supervisor told him there was construction in the back of the building; however, he was unaware there was gravel and a drop off at the back exit doors, which included the Northwest, Southwest and dining room doors to the outside. He stated he was not aware of an alternate evacuation plan. Interview, on 06/30/14 at 5:50 PM, with SRNA #4 revealed she became aware there was construction going on last week when she saw a piece of construction machinery. She stated she had seen the gravel at the back of the building; however, was unaware there was a drop off from the back exit doors. She stated she was confused because a nurse had told her she could use the back exit doors for an emergency exit; but, the Maintenance Director had told her those exits were inaccessible. Interview, on 06/30/14 at 5:52 PM, with LPN #1 revealed she was not educated until that day, 06/30/14, in regards to not using the Northwest and Southwest exit doors due to construction. Observation of the back side of the building with LPN #1 at the time of the interview, revealed she indicated staff would not be able to take residents out the three (3) exits involved (Northwest, Southwest and dining room exits), and it would be a safety issue for residents to try to evacuate them from those exits. Interview, on 06/30/14 at 5:55 PM, with SRNA #3 revealed she was unaware of the construction taking place in the back of the building until that day, 06/30/14. Interview, on 06/30/14 at 7:30 PM, with LPN #3 revealed she knew there was construction going on, but she had received no new information related to a new evacuation plan, and was unaware of the exits which were inaccessible due to construction. Interview, on 06/30/14 at 5:17 PM, with the Assistant Director of Nursing (ADON)/Unit Manager for the South hall revealed the doors at the back of the building, including the Northwest, and Southwest doors were inaccessible due to the construction. Continued interview revealed if staff were unaware of the blocked exits, this could be a safety issue if there was a fire. Interview, on 06/30/14 at 5:05 PM, with the Director of Nursing (DON) revealed she was told in the Stand Up Meeting the morning of 06/17/14, there would be construction to start on 06/18/14, which included repairing concrete; however, the construction was delayed and started on a later date. She stated, in the same meeting they were told to stay clear of the exit doors to the Northwest and Southwest hall exits because the sidewalks were being replaced outside those doors. The DON stated there were two (2) exits in the front of the building, an exit by the therapy department, and also the Northeast and Southeast hallway doors to the outside that could be used in the case of an emergency evacuation. However, she indicated she had not been educated as to the alternate routes to use for emergency evacuation. She stated the Staff Development Nurse inserviced staff related to the construction; but, she was unsure if all staff had been inserviced and instructed to use the alternate routes for emergencies. She stated staff would be unable to get residents' wheelchairs out the exits where the construction was taking place. She indicated these exits would be dangerous for people at risk for falls, and also for residents who were confused and exit seeking. According to the DON, this made it important to ensure staff were aware of which exits led to the construction zones. Interview with the Staff Development Nurse (SDN), on 06/30/14 at 5:30 PM, revealed she was told by the Director of Plant Operations during a morning Stand Up Meeting, there was construction going on outside and the facility was putting new concrete on the driveway out back. She stated she was told there would be construction workers with machines and they could not use the exits to the back of the building including the dining room exit. Continued interview revealed the DON had asked her to let staff know which doors would be inaccessible due to construction; however she was not told who to inservice and was not told exactly what the new evacuation routes would be. She stated she did an informal verbal inservice at the last Town Hall Meeting which was done on payday, Friday on 06/20/14, for the staff who picked up their checks that day. The SDN stated she told staff present, the doors which would be inaccessible due to construction would be the Southwest door, the dining room door and the kitchen door. However, she was unaware there was construction near the Northwest exit door and did not inservice staff related to that door. She stated she also told staff which doors they could use for evacuation of residents. However, she stated she was unaware of the date of the inservice, and was unable to submit the inservice or signatures of staff present from the inservice. Interview with the Administrator, on 06/30/14 at 7:00 PM, revealed she started at the facility on 05/15/14, and was told by the previous Administrator on that date there would be construction which included replacing damaged pavement on the west or back side of the building. She stated during the morning meetings she discussed with the managers the construction consisted of tearing up the concrete and re-pouring the concrete at the back of the building; however, they did not discuss the safety aspects related to the construction. She stated no formal education was provided to staff regarding which doors were affected by the construction and which doors were to be used for alternate routes. Further interview with the Administrator and previous Administrator on 07/01/14 at 12:00 PM, revealed residents did not go outside unsupervised and never went past the front porch. However, they stated there was confused and/or exit seeking residents in the building, and residents who were at risk for falls and this would be dangerous if they were to exit on to the construction zone. Continued interview revealed there was a wanderguard system in place to alert staff if a resident, at risk for elopement wearing a wanderguard device, was attempting to exit the building. They stated the wanderguard system affected the front lobby doors and the south side door, but did not affect the Northwest and Southwest Hallway exit doors or the dining room exit door. Further interview revealed once the green button was pushed by the three (3) exit doors leading to the construction zone, there would be a beeping noise and the doors would open within fifteen (15) seconds. They revealed if there was a fire, all the exit doors would disengage and open when pushed. Review of the facility's, Residents at Risk for Elopement Risk, revealed sixteen (16) residents were at risk in the facility. Review revealed three (3) residents resided on the Southwest Hallway and three (3) residents who resided on the Northwest Hallway. In addition, review of the facility's Roster Matrix revealed nineteen (19) residents who were identified at risk for falls. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following: 1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating DO NOT USE were also placed on the affected doors. 2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM),

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 25) Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacutation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff. 3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14. Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified. 4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that Construction is in progress. Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits that stated, STOP-DO NOT USE by the Maintenance Director on 06/30/14. 5. The Medical Director was notified of the IJ 07/01/14 by the DON. 6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to STOP-DO NOT USE. The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14. 7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors Construction is in process. The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all temporarily closed evacuation exits saying STOP-DO NOT USE remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed. 8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct spot checks of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator. 9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use. The State Agency validated the implementation of the facility's AOC as follows: 1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM. Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction. 2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice. Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding. Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person. Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency. 3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes. Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14. Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans. Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education. 4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged. Observation, on 078/02/14 at 11:32 AM, revealed signs stating STOP-DO NOT USE were posted on the temporarily closed evacuation exits. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM. 5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14. 6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director. 7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 26) evacuation routes and the STOP-DO NOT USE signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log. 8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing spot checks of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her. 9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator. Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party.
F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on interviews, record reviews and review of the facility's Daily Staffing Sheets and time clock punches, during the 08/01/14 survey, it was determined the facility failed to have sufficient staffing to ensure residents' care needs were met for residents residing on the facility's two (2) units as evidenced by residents' complaints and concerns of their call lights not being answered timely, and their request for assistance not being provided for seven (7) of thirty-seven (37) sampled residents (Residents #8, #16, #17, #26, #32, #33 and #36), and staff's reports of being short staffed on the night shift. Resident #26 rang his/her call light on 07/03/14, at approximately 5:30 AM for incontinence assistance; however the two (2) State Registered Nursing Assistants (SRNAs), SRNA #19 and SRNA #21, working on the South Unit where the resident resided had a conflict and did not work together to provide care for residents. SRNA #19 did not get SRNA #21 to assist her with Resident #26 because of the conflict, therefore Resident #26 had to wait until approximately 7:45 AM, for assistance to get cleaned up. Additionally interviews with residents revealed their call lights were not answered in a timely manner and their request for assistance was not provided in a timely manner due to the facility's staffing. Also, interviews with staff revealed they were short staffed on night shift, and could not always get resident care provided and call lights answered in a timely manner. After becoming aware of this information on 07/03/14, the facility initiated an investigation and identified a conflict between the two (2) SRNAs normally scheduled on the South Unit who didn't work together to provide care. However, the facility failed to address the interviewed residents' concerns with night shift and failed to address the conflict between the two (2) SRNAs assigned to the unit on the night shift which impacted resident care and left residents at risk for further neglect. (Refer to F-225 and F-226) The facility's failure to have sufficient staffing to ensure residents' care needs were met for residents was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 07/25/14, and was determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure sufficient staffing to ensure residents' care needs are met for all residents. The findings include: Review of the Census and Condition (CMS-672) Form dated 06/30/14, revealed the facility had a total census of one hundred and six (106) residents of the one hundred and twenty-four (124) total certified beds. Review of the Form revealed: seventy-six (76) residents required one (1) to two (2) staff assist with transfer; twenty-five (25) residents were totally dependent on staff for transfers; ninety (90) residents required assist of one (1) to two (2) staff for toileting; sixteen (16) residents were totally dependent on staff for toileting; eighty-six (86) residents required one (1) to two (2) staff for dressing; and, twenty (20) residents were totally dependent on staff for dressing. Review of the facility's bed listing, floor map and Resident Census for the North and South Units from 06/30/14 through 07/02/14 revealed the South Unit was a sixty (60) bed unit with a census of fifty-one (51) residents; and, the North Unit was a sixty-four (64) bed unit with a census of fifty-five (55) residents during that timeframe. Interview, on 07/23/14 at 5:49 PM, with the Director of Nursing (DON) revealed the facility did not have a policy related to staffing. She stated the Staff Development Coordinator (SDC) completed the daily scheduling of staff, and if there were call-ins the SDC or Evening Shift Supervisor attempted to provide coverage. The DON stated staff was instructed to call her or the Assistant Directors of Nursing (ADONs). She stated she did not get the Daily Assignment Sheets and did not review them, and was not always aware of the actual staffing for the previous day. Continued interview with the DON revealed during the daily clinical meeting the day's staffing was discussed. Per interview, the DON stated for night shift staffing there was no minimum, and the facility staffed four (4) nurses and four (4) State Registered Nursing Assistants (SRNAs), two (2) nurses and two (2) SRNAs on each of the facility's two (2) units, for a total of eight (8) staff at night. She stated staff should call her if there were not two (2) nurses and two (2) SRNAs on each unit during the night shift. Review of the facility's Attendance policy, undated, revealed staff were to provide the Supervisor with at least two (2) hours advance notice of his/her inability to report for his/her assigned shift. Interview, on 07/31/14 at 7:14 PM, with the SDC revealed the facility's process was acuity based which meant that staffing for the day was based on what activities were occurring in regards to admissions and discharges, whether residents were on intravenous (IV) antibiotics and other such issues. However, she stated she had a budget of total nursing staff hours to use, so staffing basically always was: for day shift (7:00 AM to 3:00 PM) three (3) nurses per unit, with two (2) as the minimum, and a goal of five (5) SRNAs, with four (4) as the minimum; evening shift (3:00 PM to 11:00 PM) three (3) nurses per unit, with two (2) the minimum, and three (3) to four (4) SRNAs minimum; and for night shift (11:00 PM to 7:00 AM) two (2) nurses per unit and two (2) SRNAs. Continued interview with the SDC revealed the day's staffing was reviewed in the morning clinical meeting, and call-ins were discussed. She stated if she became aware of staffing being short on a shift she tried to get coverage, or have staff from the previous shift stay over and staff from the next shift come in early. The SDC stated there had been a problem with communication on the evening and night shifts related to staffing, and since hiring the Evening Shift Supervisor it was better on that shift. However, she stated the 11:00 PM to 7:00 AM shift was still a problem, as sometimes she did not get the call-ins for that shift until she came in the next morning. The SDC indicated six (6) staff on night shift would not be acceptable; and if there was only one (1) SRNA on a unit at night it would be difficult to provide the care residents required. Review of the June 2014 Daily Staffing Sheets and Time Clock Punches for the 11:00 PM to 7:00 AM shift and the facility's daily resident census revealed: on 06/05/14 seven (7) staff worked the shift, one (1) nurse and two (2) SRNAs on the South Unit with a resident census of forty-eight (48), and two (2) nurses and two (2) SRNAs on the North Unit with a census of fifty-four (54); on 06/06/14 five (5) staff was present in the facility after 3:00 AM, two (2) nurses assigned on the South Unit, with a resident census of

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 0353 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 27) forty-eight (48), and one (1) nurse and two (2) SRNAs on the North Unit with a census of fifty-five (55); on 06/08/14, seven (7) staff worked the shift, two (2) nurses and one (1) SRNA on the South Unit with a resident census of forty-nine (49), and two (2) nurses and two SRNAs on the North Unit with a census of fifty-five (55); on 06/09/14, seven (7) staff worked the shift, two (2) nurses and two (2) SRNAs on the South Unit with a resident census of fifty (50), and one (1) nurse and two (2) SRNAs on the North Unit with a census of fifty-five (55); on 06/13/14, seven (7) staff was present, two (2) nurses and two (2) SRNAs on the North Unit with a census of fifty-eight (58) and one (1) nurse and two (2) SRNAs on the South Unit with a census of fifty-one (51); on 06/14/14, seven (7) staff worked, one (1) nurse, one (1) SRNA/Kentucky Medication Aide (KMA) and two (2) SRNAs on the North Unit with a census of fifty-seven (57), and one (1) nurse and two (2) SRNAs on the South Unit with a census of fifty-one (51); on 06/15/14, seven (7) total staff worked the shift, two (2) nurses and two (2) SRNAs on the South Unit with a resident census of fifty-one (51), and two (2) nurses and one (1) SRNA on the North Unit with a census of fifty-six (56); and, on 06/20/14, six (6) staff were working the shift, one (1) nurse and two (2) SRNAs on the North Unit with a resident census of fifty-six (56), and one nurse and two (2) SRNAs on the South Unit with a census of fifty-one (51). Review of the facility's Roster Sample Matrix, provided by the facility on 06/30/14, revealed the South Unit had forty (40) residents assessed to be incontinent of bladder and/or bowel, and thirty-eight (38) residents assessed to be incontinent of bladder and/or bowel on the facility's North Unit. Interview, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, with SRNA #19 revealed she worked the night shift on the South Unit and at times had been the only SRNA assigned to care for residents on the whole unit. She reported at least one (1) night a week she had to work as the only SRNA on the whole unit. SRNA #19 revealed when she worked as the only SRNA on the unit she could only complete two (2) rounds all night, instead of the every two (2) hour rounds that were required. She stated she could not complete the last round on residents who required two (2) person assist as the nurses couldn't help her if she was the only SRNA on the unit. She stated there had been a few times when there was only one (1) nurse and one (1) SRNA working on the unit; however, this had not happened often. Per interview, SRNA #19 stated she had heard there were only two (2) SRNAs in the whole building a few nights before. SRNA #19 stated Administration know we need more help; however, she indicated nothing had been done. SRNA #19 revealed she had not been able to perform incontinence care on Resident #26 and Resident #29 during her last rounds on 07/03/14, as those two (2) residents were two (2) person assist. She stated there was a conflict between her and SRNA #21 and she had not requested SRNA #21's assistance on 07/03/14 due to the conflict. Per interview, she stated she had informed the nurses and they were aware of the conflict; however, nothing had been done so far. SRNA #19 stated there were seven (7) residents who required two (2) person assist on the Southeast hall, of the South Unit she worked on. Interview, on 07/25/14 at 2:48 PM, with SRNA #6, a 7:00 AM to 3:00 PM SRNA, revealed she couldn't always get residents call lights answered as fast as residents needed them answered during her shift, and it was worse on the night shift. She indicated she sometimes came in earlier due to the staffing on night shift. Interview, on 07/24/14 at 9:48 PM, with SRNA #22, a night shift SRNA, revealed she had worked on the North Unit as the only SRNA several times before. She stated when there was only one (1) SRNA working the whole unit it wasn't fair to the residents or the SRNA. According to SRNA #22, when the unit was staffed like that, all she could do was try to get all the residents changed, and if residents rang their call lights they would have to wait, if she was in another resident's room and the nurse was busy. Continued interview with SRNA #22 revealed during the times when she was the only SRNA working the unit residents would want to get up out of bed in the morning and she would have to tell them she couldn't get them up. She stated one (1) SRNA could not take care of fifty (50) to sixty (60) residents by themselves; and could only complete about two (2) rounds the whole night, instead of the every two (2) hour rounds. She stated when she worked as the only SRNA on the unit sometimes residents would have to lay wet and soiled, and she couldn't turn residents every two (2) hours like she was supposed to. SRNA #22 reported it wasn't fair to the poor residents to be cared for like that, and she would not want her grandparents treated like that. The SRNA stated she knew SRNA #19 had worked by herself on the South Unit before. Per interview, SRNA #22 stated there had been one (1) time there was only one (1) nurse, one Certified Medication Aide (CMA)/SRNA and herself working the whole unit, and indicated she thought it was 06/06/14. Review of the Daily Staffing Sheets and Time Clock Punches for 06/06/14, on the 11:00 PM to 7:00 AM shift, revealed seven (7) staff present in the entire facility, one (1) SRNA worked the 3:00 PM to 11:00 PM and stayed over until 3:00 AM. Further review of the Staffing Sheets and Time Clock Punches revealed after 3:00 AM, only six (6) staff were present in the facility, four (4) nurses and two (2) SRNAs, (two (2) nurses and an SRNA on each unit). Further interview with SRNA #22 revealed that night was crazy, and she had called the on-call administrative person, Registered Nurse (RN) #4/Assistant Director of Nursing (ADON), who said she would try to get SRNA #22 some help; however, no one showed up to help. She stated also that night on the South Unit there were no SRNAs after 3:00 AM, when the 3:00 PM to 11:00 PM SRNAs who had stayed over to help left to go home. In addition, she stated staffing was a problem at times on both units. SRNA #22 stated all the day shift nurses were aware of the times she had worked by herself on night shift. Interview, on 07/29/14 at 3:20 PM, with SRNA #31 revealed lately the facility had been short staffed, and it depended on staffing on how long it was for residents' call lights to be answered. SRNA #31 stated if they worked short staffed it was harder to get the work done. According to SRNA #31, sometimes night shift was staffed with only one (1) SRNA on a unit, and staff would have to come in early or stay over to help the night shift SRNA out, because obviously they couldn't get all their work done by themselves. In addition, he stated when they worked short staffed they couldn't get everything documented in the Kiosk, (the facility's computer system for SRNAs). SRNA #31 indicated a lot of residents complained about their call lights not getting answered in a timely manner, and reported it could take five (5) minutes to fifteen (15) minutes for the SRNAs to be able to answer a call light. Interview, on 07/30/14 at 2:55 PM, with SRNA #18 and SRNA #20 revealed there could be and should be more staff, and there should be staffing ratios to ensure residents received the care they needed. The SRNAs indicated staff was short on pretty much every shift, and SRNAs had to hit the ground running to get everything done. They stated they were aware of there being only one (1) SRNA on night shift at times on a unit. The SRNAs reported day shift staff had to come in early to help out and evening shift would stay over to help out because only one (1) SRNA couldn't care for all the residents on the unit without help. Interview, on 07/25/14 at 9:17 AM, with Licensed Practical Nurse (LPN) #9, a 7:00 PM to 7:00 AM nurse, revealed she recalled one (1) time in June when SRNA #22 had to work by herself on the North Unit. Review of the Time Clock Punches for 06/06/14 revealed on the 11:00 PM to 7:00 AM shift, only six (6) staff present in the facility after 3:00 AM, four (4) nurses and two (2) SRNAs, one of which was SRNA #22. Continued interview with LPN #9, revealed if the nurses didn't help with providing direct care when there was only one (1) SRNA, they wouldn't be able to get their rounds completed, it would be tough. LPN #9 also stated if there was only one (1) SRNA they wouldn't be able to get residents up for the morning. Interview, 07/25/14 at 1:35 PM, with Registered Nurse (RN) #8, a 7:00 PM to 7:00 AM nurse, revealed there was still a problem with not enough SRNAs in the facility, and reported the facility was short on them often. RN #8 stated night shift staffing was supposed to be two (2) nurses and two (2) SRNAs on each of the two (2) units, but there were times when there was only one (1) nurse with two (2) SRNAs, or two (2) nurses with only one (1) SRNA on a unit. She stated when the staffing was like that it was hard to get all the work done, and if residents rang their call lights they would have to wait, and at times it might be fifteen (15) to thirty (30) minutes or longer. She stated once when she had been the only nurse, she had refused to clock in to work until another nurse was found to help her which did happen and she worked. Review of the Time Clock Punches for 06/05/14, on the 11:00 PM to 7:00 AM shift, revealed RN #8 was one (1) of only two (2) nurses working the shift for that day in the facility with only three (3) SRNAs. Review of the 06/20/14 Time Clock Punches revealed RN #8 was one (1) of only two (2) nurses working that day, with four (4) SRNAs. Continued interview with RN #8 revealed the facility census had been about full that night and the acuity of the residents had made her feel not safe being the only nurse. She stated the SRNAs worked with only one (1) SRNA at night about every other week. RN #8 stated when that happened it was pretty hard, and the nurses helped the SRNAs as they could to provide resident care during rounds. According to RN #8, when there was only one (1) SRNA on the unit they couldn't get residents who wanted to get up in the morning up, and that made her feel bad for the residents. However, she stated the work was too overwhelming for the SRNAs in the mornings as the nurses had to pass medications and could not help them out as much. She stated residents had to wait for day shift to come in at 7:00 AM to get them up. Further interview revealed residents might also have to wait a little while to get their call lights answered, especially in the early morning, between 5:00 AM and 7:00 AM it would take longer. Interview, on 07/24/14 at 7:19 PM, with RN #5/Evening Supervisor, who worked 3:00 PM to 11:00 PM, revealed the staffing for 11:00 PM to 7:00 AM, was supposed to be two (2) nurses and two (2) SRNAs on each of the facility's two (2) units. However, she stated she was aware of times when there were only three (3) nurses in the facility on the night shift but, she stated there was not a big med pass in the morning, and indicated it was okay. She indicated she attempted to get coverage if there were call-ins. Interview, on 07/26/14 at

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 28) 10:09 AM, with RN #6 revealed on the North Unit during the month of June she was aware of one (1) SRNA having to work the entire unit by herself for two (2) nights in a row. Review of the Time Clock Punches for 06/19/14 and 06/20/14 revealed on the 11:00 PM to 7:00 AM shift, SRNA #21, who was sometimes pulled to work the North Unit, worked those nights as one (1) of only three (3) SRNAs in the entire facility for that shift. She stated the nurses assisted as well as they could helping do rounds with the SRNAs to get residents cared for, until 5:00 AM when they started their medication pass. RN #6 stated the SRNAs on the South Unit also helped out those two (2) nights, as they could, but had their own residents to care for. After receiving a complaint regarding the lack of care provided by night shift staff on 07/03/14 the facility initiated an investigation. Review of the investigation report dated 07/03/14 through 07/07/14, revealed interviewable residents had been questioned regarding the care received on night shift, 11:00 PM to 7:00 AM, and Resident #16, Resident #8, Resident #17, Resident #26, Resident #36, Resident #32 and Resident #33 all expressed concerns regarding care on night shift. 1. Review of Resident #26's medical record revealed the facility admitted the resident on 07/23/12, with [DIAGNOSES REDACTED]. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #26 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #26 as requiring: extensive physical assistance of two (2) staff with his/her Activities of Daily Living (ADLs) of bed mobility, transfers and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder. Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed on 07/03/14, during the night shift he/she had pooped on himself/herself. Resident #26 stated he/she had requested assistance from SRNA #19, but the SRNA had not helped the resident. Resident #26 stated at times he/she had waited for over an hour for staff to answer his/her call light before. Resident #26 reported he/she had problems with getting staff to answer his/her call light on the night shift, 11:00 PM to 7:00 AM, and the day shift, 7:00 AM to 11:00 PM. 2. Review of Resident #32's medical record revealed the facility admitted the resident on 05/24/13, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14) which indicated no cognitive impairment and the resident was interviewable. Continued review of the MDS Assessment revealed the facility assessed Resident #32 to require extensive assistance of two (2) staffs physical assist with most of his/her ADLs including transfers, bed mobility and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of urine and always continent of bowel. Review of Resident #32's Comprehensive Care Plan, dated June 2014, revealed the resident was care planned for ADL self care deficit related to his/her [DIAGNOSES REDACTED]. Interview, on 07/03/14 at 2:14 PM, with Resident #32 revealed no one answered when he/she pressed his/her call light. Resident #32 stated he/she became incontinent and had to wait while sitting in his/her urine for assistance after ringing the call light. Additional interview, on 07/22/14 at 5:00 PM, on 07/25/14 at 3:30 PM; and, on 07/31/14 at 6:25 PM, with Resident #32 revealed when he/she had to wait to pee-pee, he/she wet his/her self. Resident #32 stated when that happened it made him/her feel no good, like a baby. Resident #32 revealed he/she had to wait about forty (40) minutes at night for his/her call light to be answered, and at times became incontinent of urine. Resident #32 stated there were not enough staff at night at times. Further interview with Resident #32 revealed he/she had talked to the people over the building before; however, nothing had been done and he/she still had to wait for the call light to be answered and wet on himself/herself. 3. Review of Resident #33's medical record revealed the facility admitted the resident on 04/22/11, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed Resident #33 as having a BIMS score of fourteen (14), which indicated no cognitive impairment and the resident was interviewable. Continued review of the MDS revealed the facility assessed the resident to require extensive assistance of two (2) staff to assist with toileting, and to be occasionally incontinent of urine and to have a [MEDICAL CONDITION]. Review of Resident #33's Comprehensive Care Plan, dated 05/19/14, revealed the resident was care planned for requiring assistance with ADLs and for the potential for complications related to his/her incontinence of bowel and bladder. Interview, on 07/03/14 at 2:25 PM, with Resident #33 revealed it took staff a long time for staff to answer his/her call light. The resident stated he/she had a weak bladder and when he/she had to go to the bathroom, he/she had to go right away. According to Resident #33, during the night it was worse, and he/she had been incontinent of urine waiting for staff to respond to the call light during the night. Resident #33 stated sometimes he/she wet on himself/herself while waiting on staff to respond to the call light. Resident #33 stated this made him/her feel bad. Further interview with Resident #33 revealed sometimes he/she became frustrated when staff did not come fast enough to assist him/her. In an additional interview with Resident #33 on 07/29/14 at 6:30 PM, revealed there was not enough staff for sure at night. Resident #33 stated at night sometimes there was only one (1) staff person to help him/her to the bathroom, and he/she needed two (2) because his/her balance was real bad. Resident #33 reported feeling frustrated at times when staff didn't answer his/her call light fast enough to help him/her. Per interview, Resident #33 indicated staff had talked to him/her regarding his/her concerns with night shift; however, no one had followed up with him/her on his/her concerns. 4. Review of Resident #36's medical record revealed the facility admitted the resident on 11/02/11, with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 06/16/14, revealed the facility assessed Resident #36 to have a BIMS score of fourteen (14) which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #36 to require extensive assistance of two (2) staff for transfer and one (1) staff assist with other ADLs except eating. Further review of the MDS Assessment revealed the facility assessed Resident #36 as being frequently incontinent of urine and always continent of bowels, and requiring a one (1) person assist toileting. Review of the Comprehensive Care Plan, dated 06/17/14, revealed Resident #36 was care planned for ADL self care deficit, and for the potential for complications related to his/her incontinence of bladder. Interview, on 07/24/14 at 2:10 PM, with Resident #36 revealed he/she took himself/herself to the bathroom because he/she had to wait twenty (20) to thirty (30) minutes sometimes for his/her call light to be answered. However, Resident #36 stated he/she often had accidents in his/her pull up adult brief because his/her bladder was so bad. Resident #36 stated staff was busy and couldn't get to him/her right away at times. Resident #36 revealed sometimes the facility was really short of help at night time, and at times he/she waited twenty (20) to thirty (30) minutes for his/her call light to be answered. 5. Review of Resident #8's medical record revealed the facility assessed Resident #8 to have a BIMS score of fifteen (15) indicating the resident was cognitively intact and interviewable. Interview, on 07/25/14 at 11:20 AM, with Resident #8 revealed during the night shift there was not enough staff and there were 'issues' due to this, such as, call lights not being answered timely. 6. Review of Resident #16's medical record revealed the facility assessed Resident #16 to have a BIMS score of fifteen (15) indicating the resident was cognitively intact and interviewable. Interview, on 07/24/14 at 1:30 PM, with Resident #16 revealed it had taken forty-five (45) minutes at times for his/her call light to be answered. Resident #16 stated there was just not enough help in the facility. 7. Review of Resident #17's medical record revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact and interviewable. Interview on 07/24/14 at 1:49 PM, with Resident #17 revealed the resident had been interviewed about his/her care concerns, but no one had followed up with him/her after concerns were expressed on 07/03/14. According to Resident #17, sometimes he/she still had to wait for as long as thirty (30) minutes for the call light to be answered. Resident #17 stated night shift and weekends were the worst times, because there was not enough staff. Interview, on 07/31/14 at 10:14 AM, with the former Administrator, who was the Administrator from 05/15/14 through 07/11/14 when the current Administrator took over, revealed in the morning meeting held Monday through Friday staffing was discussed and the current day's call-ins were reviewed. However, the former Administrator stated the previous days call-ins and actual staffing were not looked at and discussed to identify patterns or trends. She stated the Human Resources (HR) Director had given her a total number of hours worked for each department. The former Administrator stated she had never been made aware of only one (1) SRNA working on a unit during the night shift. However, review of the Daily Staffing Sheets and Time Clock Punches for the 11:00 PM to 7:00 AM shift revealed on 06/06/14 five (5) staff was present in the facility after 3:00 AM, only two (2) of which were SRNAs (with a daily census of fifty-five (55) on the North Unit and forty-eight (48) on the South Unit); on 06/08/14, only three (3) SRNAs were present in the facility for the shift (with a daily census of fifty-five (55) on the North Unit and forty-nine (49) on the South Unit); and on 06/15/14, only three (3) SRNAs were present and working the shift (with a daily census of fifty-six (56) on the North Unit and fifty-one (51) on the South Unit). If only three (3) SRNAs were working the shift it would leave one (1) unit with only one (1) SRNA. Continued interview revealed she didn't think last rounds in the morning for night shift for residents requiring two (2) person assist could be completed if there was only one (1) SRNA because the nurse would have to be on the medication cart. Per interview, the former Administrator stated having only one (1) SRNA on a unit on night shift

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 29) could negatively impact care. Interview, on 07/31/14 at 7:14 PM, with the SDC revealed she had come in at times and worked the floor as a nurse to pass medications and do treatments, or worked the floor as a nursing assistant when the staffing had been short and she couldn't find coverage. Interview, on 07/31/14 at 11:47 AM, with the current Administrator revealed he had taken over as Administrator on 07/11/14. He acknowledged being aware of staffing issues since taking over, and not having been told there was only one (1) SRNA at times on a unit during the night shift. The current Administrator stated there were vacancies and problems with call-outs which the SDC took care of during the day, and the Evening Shift Supervisor took care of in the evenings. He stated the SDC kept a report of call-outs which had been in place since he had became Administrator. Further interview revealed the SDC knew what the staffing was for the day, and would know the call-outs and find replacement staff. He in
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Store, cook, and serve food in a safe and clean way** Based on observation, interview and review of facility's policy, it was determined the facility failed to maintain sanitary conditions as evidenced by the soiled appearance of the kitchen, with food build up on the walls, splatters on the wall and the incomplete cleaning schedule for the month of June 2014. The findings include: Review of the facility's policy titled Cleaning and Sanitizing Dietary Areas and Equipment, undated, revealed all kitchen areas and equipment should be maintained in a sanitary manner, and be free of build-up of food, grease or other soil. Observation during the initial kitchen tour, on 06/30/14 at 1:15 PM, revealed the kitchen had a general appearance of food build-up on the walls and food splatters on equipment. Further observation of the kitchen revealed two (2) trash can liner cases located on an open rack near the food preparation (prep) table with a soiled, greasy appearance. Observation also revealed three (3) electrical plugs on conduit extensions from the floor with dried food particles at the base and around the top of the electrical plug box. Continued observation revealed dried brown stains on the side of the dish lowrater, which was located next to the coffee machine on the resident tray line, and the dried brown stains had run down the side of the dish lowrater. Observation, on 07/01/14 at 10:55 AM, revealed the back of the ice cream freezer had dried stains which ran down the back of the freezer. Interview with the Dietary Manager, on 07/01/14 at 11:10 AM, revealed the cleaning list with the month and year on it was located on the dry storage room door. She stated the kitchen staff was assigned specific areas and equipment to clean, and she checked the cleaning on a weekly basis. Review of the cleaning list titled Cleaning Schedule, dated June 2014, revealed staff names were located beside each cleaning task; however, there were no dates to indicate when the task was to be completed, or when it had been completed by the staff assigned to it. Continued review revealed the Cleaning Schedule did not indicate if the cleaning task was to be completed daily or weekly. Further review revealed check marks were located beside the staff person assigned to a task, indicating it had been completed; however, some staff had not made check marks to indicate their task had been completed. Interview with Dietary Aide #1, on 07/03/14 at 10:55 AM, revealed the cleaning schedule located on the dry stock room door was for cleaning tasks to be completed daily and monthly. He stated staff were to use a cleaning cloth that was kept in a sanitizer solution for cleaning, and the sanitizer should be changed often. Dietary Aide #1 revealed each staff member was assigned to specific areas to clean, and when the area had been cleaned staff was to make a check mark on the list indicating it had been completed. He stated the Dietary Manager checked often to see if the cleaning had been done, and would write up staff if the cleaning had not been done. Interview with Dietary Aide #2, on 07/03/14 at 11:00 AM, revealed the cleaning schedule located on the dry stock room door was a daily and weekly cleaning schedule. Dietary Aide #2 stated the Dietary Manager instructed staff on how to clean. She stated the staff was to use sanitizer to clean surfaces. She further revealed the cleaning schedule was rotated and she might be assigned to clean the walls, then might be assigned to clean the milk cooler later. According to Dietary Aide #2, staff were to check off on the list when their assigned cleaning was completed, and they had a full month to complete all the cleaning. Interview with Cook #1, on 07/03/14 at 11:05 AM, revealed the cleaning schedule was located on the dry stock room door. Cook #1 stated the Dietary Manager instructed him on how to clean, using a rag in sanitizer and changing the sanitizer often. He stated the cleaning list was for weekly cleaning, and the assigned staff was to check off their assigned cleaning as completed. Interview with Cook #2/Supervisor, on 07/03/14 at 11:10 AM, revealed the cleaning list was located on the dry stock room door. He stated the cleaning schedule was for weekly cleaning, and he assisted the Dietary Manager to check on the weekly performed by staff. He indicated the Dietary Manager trained staff on how to clean, and he had prior training and experience himself on cleaning. Cook #2/Supervisor stated he used a cleaning cloth placed in sanitizer and cleaned the surfaces in the kitchen. He revealed the sanitizer was changed two (2) to three (3) times per day. Cook #2/Supervisor stated he usually was responsible for weekly cleaning of the ovens, steam table and steamer. Interview with Dietary Aide #3, on 07/03/14 at 11:12 AM, revealed the cleaning schedule was located on the store room door, and was divided into four (4) weeks. He stated the Dietary Manager instructed staff on cleaning, and stated he used bleach in the dishroom and sanitizer on a rag to clean in the kitchen daily. Dietary Aide #3 revealed the assigned areas for staff to clean were changed monthly. He stated he made a check mark when the cleaning was completed. Interview with the Dietary Manager, on 07/03/14 at 11:20 AM, revealed the current cleaning schedule form was made from the corporate form which did not list all the equipment or areas of the facility's kitchen. She stated Cook #2/Supervisor assisted her in making weekly observations of the cleaning performed by staff and assisted staff as needed. She revealed she made weekly observations of the cleaning schedule list to ensure the cleaning assigned had been completed and checked off. The Dietary Manager stated she needed to change the cleaning schedule to include a separate daily cleaning list to ensure the kitchen areas were cleaned daily after meal production.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for one (1) of thirty-seven (37) sampled residents (Resident #6). Observation revealed staff did not wash their hands prior to exiting the isolation room for Resident #6, who was in contact isolation for Clostridium Difficile (C-diff) of the stool (a bacterium that could cause symptoms ranging from diarrhea to life threatening inflammation of the colon), and Escherichia Coli (E-coli) ESBL (Extended Spectrum Beta Lactamase) and [MEDICATION NAME] Faecium VRE ([MEDICATION NAME] Resistant [MEDICATION NAME]) of the urinary tract. ESBL and VRE are multi-drug resistant organisms and were the bacterial source of the resident's Urinary Tract Infection (UTI). Also, staff failed to remove their soiled gloves and wash their hands after providing incontinence care for Resident #6, and prior to touching objects in the resident's room. In addition, staff performed Foley catheter (indwelling urinary catheter) care by cleaning the catheter tubing upwards towards the catheter insertion site. The findings include: Review of the facility's At-A-Glance-Hand Washing and Use of Gloves policy, effective December 2010, revealed handwashing was the single most important measure of preventing the spread of infections. Continued review revealed handwashing was to be performed before and after resident care and after handling contaminated articles. Review of the facility's Isolation-Categories of Transmission Based Precautions policy, revised August 2012, revealed contact precautions were to be used for residents known or suspected to be infected with microorganisms which could be transmitted by direct contact with the resident, or indirect contact with environmental surfaces or resident care items in the resident's environment. Continued review revealed while caring for a resident staff were to: change their gloves after having contact with infective material, such as feces; remove the gloves before leaving the room, and perform hand hygiene; not touch potentially contaminated environmental surfaces or items in the resident's room after removal of gloves and hand washing. Review of the facility's policy titled Clostridium Difficile, revised August 2013, revealed when caring for residents with diarrhea or fecal incontinence caused by[DIAGNOSES REDACTED], staff were to maintain vigilant hand hygiene. Further review revealed staff were to use gloves when caring for the resident with a[DIAGNOSES REDACTED] infection, and wash their hands with soap and water upon exiting the room. Review of the facility's policy titled Foley Catheter Care, effective December 2010, revealed the purpose of catheter care was to prevent possible urinary tract infections from bacteria spreading from the perineal area and external catheter into the bladder. Further review revealed perineal care consisted of washing the perineal area and catheter with clean, warm, soapy water followed by rinsing the areas. In addition, review revealed the policy did not specify under the procedure section in which direction the Foley catheter was to be cleaned. Review of Resident #6's medical record revealed [DIAGNOSES REDACTED]. Review of the laboratory (lab) information and reports revealed a stool for[DIAGNOSES REDACTED] was collected 06/10/14 and reported on 06/11/14 as positive for infection. Review of the physician's orders [REDACTED]. Continued review of the physician's orders [REDACTED]. Additionally, continued review of the lab information and reports revealed a urine was collected on 06/27/14 and reported on 06/29/14 as E-coli ESBL and [MEDICATION NAME] Faecium VRE. Further review of the physician's orders [REDACTED]. 1.

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 30) Observation of Resident #6's room, on 07/01/14 at 4:10 PM, revealed a sign outside the door which stated, See nurse before entering, contact isolation, and a plastic bin with drawers beside the door which contained Personal Protective Equipment (PPE), including gowns, gloves and shoe covers for staff. Observation from 4:10 PM until 5:05 PM revealed Licensed Practical Nurse (LPN) #6 and LPN #7 donned the PPE, entered Resident #6's room and performed Foley catheter care and incontinence care related to the resident having had a large diarrhea stool. Continued observation revealed the two (2) nurses then performed a skin assessment, measured wounds and performed dressing changes to pressure ulcers on the resident's right buttock and left heel using infection control technique. Observation revealed LPN #7 placed the soiled linens in a clear bag and then a yellow bag, removed her PPE and placed it in a red biohazard hamper in the room, opened the door and left the room without washing her hands. LPN #7 was observed to go across the hall and into the dirty utility room, using a keypad punch to open the door. Further observation revealed SRNA #16 removed her PPE and exited the open door without washing her hands, and proceeded into the dirty utility room. In addition, LPN #6 removed her PPE, and without washing her hands exited the open door of the resident's room, and went down the hall and through the nurse's station entrance. Interview with SRNA#16, on 07/01/14 at 5:05 PM, revealed she had been instructed to remove her PPE, and go straight to the soiled utility room and wash her hands in the soiled utility room after exiting an isolation room. She stated this would keep her from taking off the shoe covers and then going back across the resident's room to the bathroom to wash her hands, which could cause her to re-contaminate herself. She stated she had not had a recent inservice related to isolation procedures or infection control. Interview with LPN #6, on 07/01/14 at 5:07 PM, revealed she had left the isolation room and gone to the sink at the nurse's station to wash her hands and did not touch anything but the sink. She stated she would not want to remove her PPE and then walk back across the isolation room to wash her hands because she could cross contaminate herself. Interview with LPN #7, on 07/01/14 at 5:08 PM, revealed she did not wash her hands before exiting the isolation room because this would cause cross contamination if she walked back across the resident's room to the bathroom to wash her hands. She stated she could have contaminated the resident's door by opening the door, and also the keypad and door to the soiled utility room if there were germs on her hands after removing her gloves. She stated there had been no recent inservice related to contact precautions or PPE. Interview with the Infection Control Nurse, on 07/02/14 at 10:30 AM, revealed staff should wash their hands after removing the PPE and prior to leaving the contact isolation room. She further stated staff should wash their hands again when the soiled linens were put away after exiting the contact isolation room. 2. Continued observation of Resident #6, on 07/02/14 at 1:50 PM, revealed the sign stating, See nurse before entering, contact isolation, and the plastic bin with PPE, remained outside the resident's room door. Observation revealed SRNAs #16 and #17 donned the PPE and entered Resident #6's room to provide incontinence care and weigh the resident. Observation of Foley catheter care revealed SRNA #17 cleansed bowel movement from the resident's perineal area, changed the wet wipe but not her gloves, and cleansed the Foley catheter tubing, which was covered with stool, upwards towards the vaginal area. Observation revealed SRNA #16 then cleaned the resident's buttocks and applied protective ointment, holding the tube with her soiled gloves. Continued observation revealed SRNA #17 cleaned stool from Resident #6's buttocks, and also handled the protective ointment tube with her soiled gloves while applying ointment to the resident's buttocks. SRNA #17 placed the protective ointment in the resident's bedside drawer. Observation revealed SRNA #16 removed one (1) pair of gloves and stated she had double gloved, and proceeded to place a lift sling under Resident #6. SRNA #16 was further observed to move the mechanical lift towards the resident and handled the lift controls to maneuver the lift down and then up again after hooking the lift pad onto it. The SRNAs were observed to obtain Resident #6's weight with the mechanical lift, unhook the lift pad, and remove the lift pad from under the resident. Observation revealed SRNA #16, with the same gloves, handed Resident #6 a lanyard (a rope or cord, typically worn around the neck, shoulder, or wrist) and placed it around the resident's neck, and handed the resident his/her purse and glasses. Continued observation revealed SRNA #17 removed her PPE, opened the door and exited the room without washing her hands, taking the yellow bag of soiled linens out the door and down the hall. SRNA #16 was observed to stay in the room while housekeeping cleaned the mechanical lift, then remove her PPE and exit the room without washing her hands. Interview with SRNA #16, on 07/02/14 at 2:30 PM, revealed she could double glove and take off the first pair after incontinence care and handle the mechanical lift because housekeeping cleaned the lift after use due to the resident being in contact isolation. However, she stated she should have washed her hands prior to handing the resident his/her personal items, such as the lanyard, glasses and purse. She stated she exited the room without washing her hands because after she removed her PPE she did not want to go back across the resident's room and contaminate herself by using the resident's bathroom sink to wash her hands. Interview with SRNA#17, on 07/02/14 at 2:45 PM, revealed she knew she was to clean the Foley catheter from the vaginal area down towards the urinary drainage bag; however, she had inadvertently cleaned the wrong way in an attempt to get the bowel movement cleaned up. She stated she had contaminated the protective ointment with her soiled gloves and placed it in the resident's top drawer which could contaminate other items in the drawer. She stated she did not know how she was to use the ointment without contaminating the tube. SRNA #17 stated she had exited the room without washing her hands after removing the PPE and washed her hands down the hallway at the nurse's station as she did not want to walk back across the resident's room without her PPE. Record review revealed an inservice was given on 06/06/14 related to Contact Isolation,[DIAGNOSES REDACTED], and Handwashing. Review of the staff signatures for the inservice revealed SRNA #17 and LPN #6 had attended; however, there were no signatures for SRNA #16 and LPN #7 indicating they had attended the inservice. Continued interview with the Infection Control Nurse, on 07/03/14 at 4:30 PM, revealed staff were to wash their hands prior to exiting isolation rooms, and again after exiting the room if handling soiled items, such as biohazard bags. She stated staff should wash their hands and use new gloves before performing Foley catheter care, and were to clean the catheter tubing from the vaginal area down towards the drainage bag. The Infection Control Nurse further stated there had been no recent inservice related to catheter care; however, staff received inservices related to this on orientation and yearly. She stated she randomly observed and audited catheter care and incontinence care, and if she saw a problem she stopped the staff right then and corrected them. The Infection Control Nurse revealed she never taught staff to double glove, and she had inserviced staff related to glove usage by telling them to change gloves and wash their hands as many times as necessary when providing care. She stated the protective ointment would be contaminated if handled with soiled gloves. She further stated staff should have removed their soiled gloves and washed their hands before handling items in the room, such as the mechanical lift and Resident #6's personal items. Continued interview revealed she did not teach staff they could not walk back across the isolation room to the bathroom to wash their hands after removing the PPE. She stated she recently did an inservice related to contact isolation,[DIAGNOSES REDACTED], and blood borne pathogens. In addition, she stated all new hires receive an infection control inservice, and this was also done yearly.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on observation, interview, and review of the facility's Disaster Preparedness Manual, Fire Emergency Guidelines and Evacuation Plan, during the 07/03/14 survey, it was determined the facility's Administrator failed to have an effective system in place to ensure the residents' environment remained as free from accident hazards as possible, and failed to ensure the facility's evacuation route was updated and facility staff was trained and knowledgeable regarding which fire exits were appropriate for evacuation during the construction, which affected three (3) exits identified by the facility as emergency exits. On 06/24/14 the facility began construction by removing the concrete pavement outside the Northwest hallway exit and and the Dining room exit and on 06/27/14 the the Southwest exit door had pavement removed, affecting the safe path to a public way for these three (3) exits. Although these three (3) exits were designated as fire evacuation exits, observation revealed the three (3) exit doors led to drop offs, large gravel, rebar and an uneven rocky and dirt surface. The facility's emergency exit routes included these exits at the end of the Northwest and Southwest hallways. There was a total of sixty (60) of the facility's one hundred and twenty-four (124) residents residing on these hallways with the potential to be affected in case of an emergency evacuation. Also, the map posted in the Dining room revealed arrows leading to the

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 31) outside, indicating the door located in the dining room was an exit route, although there was construction outside that exit. (Refer to F-323, F-518 and F-520) The facility's Administrator's failure to have an effective system in place to ensure the residents' environment remained as free from accident hazards as possible, and each resident received adequate supervision to prevent accidents was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/30/14 and determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure compliance with systemic changes. Based on interview, record review, and review of the facility's investigation reports and policies, during the 08/01/14 survey, it was determined the facility's Administrator failed to ensure their abuse and neglect policies were implemented by staff as evidenced by failing to ensure all allegations of abuse, including neglect were investigated thoroughly, and failing to ensure residents were protected from further neglect. On 07/03/14, Resident #26 rang the call bell for incontinence care assistance at approximately 5:30 AM; however was not assisted until approximately 7:45 AM, (two hours and fifteen minutes later). Interview with the day shift State Registered Nursing Assistant (SRNA), who assisted Resident #26 at 7:45 AM, revealed the resident was soaked with urine and covered in bowel movement. Staff interviews further revealed other residents were also left soaked in urine or soiled with bowel movement the morning of 07/03/14, after day shift reported to work at 7:00 AM. These residents included #5, #27, #28, and #29. Although Administration became aware of the allegations related to Resident #5, #26, #27, #28, and #29, on 07/03/14, and completed an investigation, the investigation was not thorough and was not reviewed by the Director of Nursing (DON) or the Administrator. In addition, the investigation revealed a conflict between the two (2) SRNA's who worked the South Unit on the night shift noting they did not work together as a team for residents requiring two (2) person assist with ADL's. However, Administration failed to address this conflict between the two (2) SRNA's to prevent further resident neglect. (Refer to F-224, F-225, F-226) The facility's Administrator's failure to have an effective system in place to ensure residents were protected from neglect was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/25/14 and was determined to exist on 07/03/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at 42 CFR 483.75 Administration (F-490) at a Scope and Severity of a E while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors to ensure compliance with systemic changes. The findings include: Reference F-323, F-518 and F-520 1. Review of the facility's, Disaster Preparedness Manual, dated January 2005, revealed the fire safety procedure plan which noted what staff were to do when preparing for an evacuation. Review revealed when the fire alarm sounded staff were to first check the primary exit route, and if it was clear and safe, use that exit if evacuation of the facility was ordered. Review of the facility's Fire Emergency Guidelines, undated, for the North and South Units revealed staff were to check the primary exit route, and if it was blocked they were to use the secondary route. Review of the maps on 06/30/14, posted across from the nurse's station on both units and in the Dining room revealed the Northwest hallway exit door, Southwest hallway exit door, and Dining room exit door were marked with arrows indicating they were exit routes to be taken. Observations on 06/30/14 from 5:15 PM to 5:24 PM revealed outside the dining room exit door a concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar (steel bar used in construction to reinforce concrete); outside the Northwest hallway exit door a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar; and, outside the exit door at the end of the Southwest hallway a ramp which led to a four and a half (4.5) inch drop off with gravel. Further observation on 06/30/14 from 5:15 PM to 5:24 PM revealed there were no signs posted at the Southwest hallway exit door, Northwest hallway exit door, and dining room exit door to alert staff, residents, and visitors these exits were not accessible due to construction. Also, there was no posting of new evacuation routes in case of fire or other emergencies due to the exits not being accessible, despite the facility's knowledge there was not a safe pathway to a public way due to construction for those three (3) exits. The facility's Administration provided no documented evidence it had evaluated and/or revised the evacuation plan related to the Northwest hallway fire exit, the Southwest hallway fire exit or the dining room fire exit having no safe path to a public way. In addition, there was no documented evidence staff was trained and knowledgeable regarding which fire exits were appropriate for evacuation during construction. Interviews with staff revealed they would have used the Northwest hallway, Southwest hallway, and dining room exits to the outside if an emergency arose which required residents to be evacuated from the facility. Interviews revealed they did not think those exits had been affected and they had not been told by the facility to not use those exits. Interview, on 06/30/14 at 5:05 PM, with the Director of Nursing (DON), revealed she was told on the morning of 06/17/14, during the Stand Up Meeting construction was to start on 06/18/14 and this included repairing concrete and those present were told to stay clear of the exit doors to the Northwest and Southwest hallway exits as the sidewalks were being replaced outside those doors. She revealed the Staff Development Nurse (SDN) inserviced staff related to the construction; but, she was not sure if all facility staff had been inserviced by the SDN. The DON reported she had not been inserviced as to an alternate evacuation route for an emergency evacuation. Per interview the DON stated knowledge of an alternate evacuation plan and inservicing staff on it would be important to have as staff would not be able to get residents' wheelchairs out the exits where the construction was taking place. Interview with the SDN on 06/30/14 at 5:30 PM, revealed she was told by the DON to inform staff of which doors would be inaccessible due to construction; however, she was not told who to inservice and was not told exactly what the new evacuation routes would be. According to the SDN, therefore she did an informal verbal inservice at the last Town Hall Meeting which was held on payday Friday on 06/20/14 with staff who were picking up their paychecks. Review of the facility's, Town Hall Meeting and Inservice Agenda dated 06/20/14, revealed there was a list with bullets which included a bullet stating, construction on drive. However, continued review revealed no written information referencing the information provided. Further review revealed there were twenty-eight (28) staff signatures listed for the inservice out of the one hundred and fifty (150) employees in the facility. Interview, on 06/30/14 at 7:00 PM, with the Administrator revealed she came to work at the facility on 05/15/14, and was told by the previous Administrator that day there would be construction taking place and this included replacing damaged pavement on the west or back side of the building. She stated she learned on 06/17/14 construction would be starting on 06/18/14; however, the construction was delayed and did not start until 06/24/14. The Administrator stated during the morning meetings she discussed the construction every few days. According to the Administrator, she talked about how the construction would consist of tearing up the concrete and re-pouring it at the back of the building. Per interview she stated however, they had not discussed the safety aspects related to the construction. Continued interview revealed she knew the SDN had inserviced staff at the last Town Hall Meeting which occurred on 06/20/14; but the SDN had not been told to specifically inservice all staff, and was not appraised of any new evacuation plan. The Administrator stated the facility's evacuation plan stated if an exit could not be used for some reason, staff should use another exit. She stated however, if staff was unaware they could not use certain fire exit doors, that could delay residents getting out of the building in an emergency situation. Further interview with the Administrator revealed she had never been through construction in a building as an Administrator, and had not thought about needing a new emergency evacuation plan. However, she stated, in hindsight she should have ensured there was a new emergency evacuation plan specifically addressing the three (3) emergency fire exits affected during the construction. She indicated she should have ensured formal inservicing and education for all staff related to construction and which doors were to be used for alternate evacuation routes. She stated she had not discussed any safety aspects of the construction with the Quality Assurance (QA) Committee meeting held prior to the construction starting; however, indicated she had informed the QA members construction was getting ready to start. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following: 1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 32) plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating DO NOT USE were also placed on the affected doors. 2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff. 3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14. Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified. 4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that Construction is in progress. Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits that stated, STOP-DO NOT USE by the Maintenance Director on 06/30/14. 5. The Medical Director was notified of the IJ 07/01/14 by the DON. 6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to STOP-DO NOT USE. The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14. 7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors Construction is in process. The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all temporarily closed evacuation exits saying STOP-DO NOT USE remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed. 8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct spot checks of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator. 9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use. The State Agency validated the implementation of the facility's AOC as follows: 1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM. Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction. 2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice. Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding. Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person. Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency. 3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes. Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14. Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans. Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education. 4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged. Observation, on 078/02/14 at 11:32 AM, revealed signs stating STOP-DO NOT USE were posted on the temporarily closed evacuation exits. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM. 5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14. 6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 33) notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director. 7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the STOP-DO NOT USE signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log. 8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing spot checks of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her. 9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator. Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party. Reference to F-224, F-225, F-226 2. Review of the facility's policy titled, Abuse, Neglect and Misappropriation, dated April 2013 revealed abuse and neglect of residents was prohibited. Review of the Policy revealed staff were to be trained on abuse to include what constituted abuse, neglect or misappropriation of resident property. The Policy revealed all allegations of abuse were to be investigated, and the Administrator/designee was to make all reasonable efforts to investigate and address alleged reports, grievances and concerns. Further review revealed Social Services or the Chaplain were to follow up with the resident to monitor his/her emotional well-being after an incident, and families were to be notified of the outcome of the investigation. Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed that morning, he/she had waited for over an hour for someone to respond to his/her call light before, and had pooped on himself/herself during the night before as a result of having to wait for staff's assistance. The resident further stated SRNA #19 had been assigned to his/her care the night before when he/she had pooped on himself/herself, and did not change him/her after he/she asked the SRNA to be changed. Resident #26 revealed staff did not changed him/her until day shift reported to work that morning. Interviews with day shift State Registered Nurse Aides (SRNA's), and nurses were conducted revealed other residents were left wet and/or soiled the morning of 07/03/14 who were assigned to SRNA #19 including Residents #5, #27, #28, and #29. Further, staff interviews revealed there was a conflict between SRNA #19 and SRNA #21 who both worked the night shift on the South Unit, stating they did not work together as a team and did not answer call lights for each other. Continued staff interviews revealed this impacted the care the residents received when the two (2) SRNA's were assigned as the only SRNA's on the unit. The facility conducted an investigation which was initiated on 07/03/14 and conducted through 07/07/14 related to Resident #26's concerns regarding the lack of care on the night shift. Review of the investigation revealed there was no documented evidence non-interviewable residents who could not speak for themselves who were cared for by SRNA #19 on 07/03/14, had been assessed, or their families/responsible parties interviewed. Administration failed to ensure these residents were assessed for signs of neglect related to care not provided by night shift staff. Also, as part of the investigation the facility interviewed staff who cared for Resident #26 on 07/03/14. According to the staff interviews, per the investigation, Resident #26 was noted to be very soiled with urine and bowel movement going up to her/his chest and backside, on the morning of 07/03/14, and Resident #29 did not appear as though incontinence care had been performed on the previous shift and the bed was very wet. In addition, staff interviews further revealed there was a conflict between SRNA #19 and SRNA #21 who worked the night shift on the South Unit and they did not work together to assist residents who required two (2) staff to assist with care. The staff interviews from the investigation, also revealed SRNA #9 had complained that her whole group of residents was left wet on the morning of 07/03/14, and LPN #12 and the ADON/Unit Manager of the South Units was aware of SRNA #9's concerns. However, the facility failed to interview SRNA #9 as part of the investigation. Although the staff interviews revealed the conflict between SRNA #19 and SRNA #21, Administration failed to address and investigate this conflict which was impacting the care of the residents. Interview, on 07/23/14 at 5:49 PM and 07/25/14 at 7:20 PM, with the Human Resources (HR) Director, DON, and Social Services Director (SSD) revealed, it would be neglect of residents if incontinence care was not performed timely or when requested. Per the SSD, the investigation initiated on 07/03/14, was focused on Resident #26, due to her/his voiced concerns. The SSD further acknowledged she should have involved nursing in the investigation to assess those residents who could not speak for themselves and were left wet on 07/03/14 including Residents #5, #28, #29, and #27. Continued interview revealed she was unaware of a conflict with the night shift staff, and had not realized this was a concern through reviewing the interviews with staff. Even though staff had written statements regarding the conflict. The SSD stated the investigation was a team approach and the former Administrator, who was the Administrator during the investigation, reviewed the initial investigation report and the final five (5) day report. The SSD stated the former Administrator had decided the allegations from the morning of 07/03/14 were unsubstantiated, because the
F 0518 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Train all employees on what to do in an emergency, and carry out announced staff drills.** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on observation, interview, record review, and review of the facility's Fire Emergency Plan and Evacuation Plan, during the 07/03/14 survey, it was determined the facility failed to have an effective system to ensure the facility's emergency evacuation plan was updated related to ongoing construction, and to ensure all employees were trained in emergency procedures related to safety and evacuation. On 06/24/14, construction began outside the Northwest hallway exit and and the Dining room exit and on 06/27/14 the Southwest hallway exit door had pavement removed, affecting the safe path to a public way for these three (3) exits. The facility failed to update the emergency evacuation plan related to the Northwest hallway, Dining room, and Southwest hallway exits and failed to provide training to staff regarding using the exits as a means of evacuation during the construction. Staff interviews revealed they would have used the affected exits to the outside if an emergency arose which required residents to be evacuated. (Refer to F-323) The facility's failure to ensure the emergency evacuation plan was updated and failure to have an effective system in place to ensure staff were adequately trained in emergency procedures related to safety and evacuation was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 06/30/14, and was determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure

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F 0518 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 34) the emergency evacuation plan is updated and all staff are trained in emergency procedures related to safety and evacuation. The findings include: Review of the facility's, Disaster Preparedness Manual, dated January 2005, revealed a fire safety procedure plan which stated when preparing for an evacuation after a fire alarm sounded, staff should first check the primary exit route and if it was clear and safe use that exit. Further review of the fire safety procedure plan revealed no documented evidence it had been changed to address the construction taking place outside the Northwest hallway exit door, the Dining room exit door, or the Southwest hallway exit door. Additionally, the facility was unable to provide documented evidence they had developed and implemented a revised emergency evacuation plan specific to address the three (3) exits involved in construction. Review of the facility's, Fire Safety Procedures Orientation Training, undated, revealed in an evacuation staff should first check the primary exit route, as indicated in the fire safety procedure plan, and use that exit if it was clear and safe. Review of the facility's, South Nursing Department Fire Emergency Guidelines and North Nursing Department Fire Emergency Guidelines both undated, revealed staff should check the primary exit route and if it was blocked use the secondary route. Review of the facility's maps for the Southwest hallway and Northwest hallway revealed the exit doors at the end of the hallways were noted to be used as an exit route. Review of the facility's map in the dining room revealed the exit door located there was noted to be used as an exit route. Review of the Town Hall Meeting and Inservice Agenda dated 06/20/14, revealed a bullet list which included construction on drive. There was no written information regarding what the inservice included for reference. Continued review revealed there were twenty-eight (28) staff signatures listed on the inservice out of one hundred and fifty (150) employees in the facility. Further review of the facility's documentation revealed no documented evidence the facility had provided inservice training for all staff regarding the fire exits affected by the construction and on any changes to the facility's evacuation plan. Observations on 06/30/14 from 5:15 PM to 5:24 PM, of the three (3) areas affected by construction revealed: the dining room fire exit door had a concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar (common steel bar used widely in construction to reinforce concrete); the Northwest hallway fire exit had a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar; and the Southwest hallway fire exit door had a ramp which led to a four and a half (4.5) inch drop off with gravel. Observation outside all three (3) of these fire exit doors revealed there was a dirt and rocky uneven surface. Additional observation on 06/30/14 revealed no signs were posted at the affected exits to alert staff these exits were not accessible due to the construction, and there were no new evacuation routes observed posted. Interview with the Director of Plant Operations, on 06/30/14 at 2:20 PM, revealed construction began on 06/24/14. Per interview, he was unaware of any updated evacuation plan related to the new construction. He stated staff including himself received no formal training related to any new evacuation plan due to construction although these three (3) exits were not safely accessible in case of an emergency evacuation. Interview, on 06/30/14 at 5:01 PM, with the Social Service Director (SSD) revealed she knew about the construction project. However, she was unaware of any new evacuation plan and thought the staff were to use the Northwest, and Southwest exits in the case of an emergency situation. The SSD stated staff should have been educated on a new evacuation plan due to construction because under the current evacuation plan the Northwest and Southwest exits as well as the dining room exit were to be used in the case of an emergency evacuation. Interview, on 06/30/14 at 3:16 PM, with State Registered Nursing Assistant (SRNA) #1 revealed if an emergency situation arose she would have used the Northwest hallway, Southwest hallway, and Dining room exits to evacuate residents. She stated even though she was aware of the construction, as far as she knew those exits were not affected by it. Interview, on 06/30/14 at 3:20 PM, with Housekeeper #1 revealed she had not been told not to use the Northwest hallway, Southwest hallway or Dining room exits, and indicated she would have used the exits to evacuate residents in the case of an emergency. Interview, on 06/30/14, at 5:15 PM, with Licensed Practical Nurse (LPN) #4 revealed prior to 06/30/14 she had not been notified of any new evacuation routes or that there was construction outside the building. However, she received education today, 06/30/14, related to a new emergency plan after the State Survey Agency entered the building. Interview, on 06/30/14 at 5:17 PM, with the second shift Supervisor/Registered Nurse (RN) #5 revealed she did not formally inservice all of her staff not to use the exits affected by the construction; however, did verbally tell some of the staff. She stated formal inservicing related to a new evacuation plan in the case of an emergency had started that day, 06/30/14, after the State Survey Agency entered the building. Interview, on 06/30/14 at 5:30 PM, with Housekeeper #2 revealed his supervisor informed him of the construction in the back of the building; however, he had not received an inservice related to a new evacuation plan in case of emergency due to the construction. Interview, on 06/30/14 at 5:52 PM, with LPN #1 revealed she was not educated prior to 06/30/14 regarding not using the Northwest hallway and Southwest hallway exit doors because of the construction. She stated the State Survey Agency was already in the building before she received any inservicing. She indicated staff should have been formally inserviced regarding not using the affected exits last week when construction began. Interview, on 06/30/14 at 5:55 PM, with SRNA #3 revealed she had not been aware there was construction at the back of the facility until 06/30/14. She stated she had received education that day, 06/30/14, by the Assistant Director of Nursing (ADON)/Unit Manager of the North Hall. SRNA #3 indicated she had also been told that day staff was not use the affected exit doors at the back of the building. Interview, on 06/30/14 at 7:30 PM, with LPN #3 revealed even though she knew construction was taking place, she had not received any new information regarding a new evacuation plan. She indicated she was unaware of the affected exits which were not accessible because of the construction. Interview, on 06/30/14 at 5:17 PM, with the Assistant Director of Nursing (ADON)/Unit Manager for the South hall revealed before the construction started there had been no formal inservices related to a new evacuation plan in the case of an emergency; however, the facility had initiated formal inservicing that day, 06/30/14. She stated educating the staff prior to the construction would have been important, as the Northwest hallway and Southwest hallway exit doors were not accessible due to the construction. Interview, on 06/30/14 at 5:05 PM, with the Director of Nursing (DON) revealed she was told on 06/17/14 in a Stand Up Meeting, that construction would start on 06/18/14; however, the construction was delayed and started at a later date. According to the DON, staff in the Stand Up Meeting were told not to use the exit doors in the Northwest hallway and Southwest hallway as the sidewalks were being replaced outside those doors. However, she had not been educated regarding alternate routes to use for emergency evacuation. The DON stated it would be important to have an alternate evacuation plan and to ensure all staff were inserviced on the plan. She stated the Staff Development Nurse (SDN) inserviced staff regarding the construction; however, she did not know if all staff had received the inservice and if alternate routes for emergencies was included in the inservice. Interview with the Staff Development Nurse (SDN) on 06/30/14 at 5:30 PM, revealed she was told by the Director of Plant Operations during a morning Stand Up Meeting, about the construction project and was told staff could not use the exits to the back of the building including the Dining room exit. Continued interview revealed the DON had asked her to let staff know which doors would be inaccessible due to construction; however she was not told who to inservice and was not formally notified of new evacuation routes. She stated she did an informal verbal inservice at the last Town Hall Meeting, on 06/20/14, and told the staff present which doors would be inaccessible due to construction, which were the Southwest door, the Dining room door, and the kitchen door. She stated she also told staff to they could use the front doors, therapy doors, north side door and south side door, and the door to the employee parking lot for evacuation of residents. The SDN stated she also told staff during the inservice if the residents were in the dining room during an evacuation they were to use the employee parking lot doors or the front doors to exit. According to the SDN, she told staff in the inservice if residents needed to be evacuated from the Southwest wing they were to use the Southeast exit door to the parking lot. The SDN further stated she had also verbally inserviced the South Unit SRNAs and nurses, the Activity Director, the Minimum Data Set (MDS) Coordinators and the wound nurse related to the construction and which doors to use for an emergency evacuation. However, she stated she was unaware of the date of the inservice, and was unable to submit the inservice or signatures of staff present from the inservice. Further interview revealed she was unaware there was construction near the Northwest exit door and did not inservice staff related to that door. She stated she was unaware of any new formal evacuation plan in case of fire or other emergency. Review of the Town Hall Meeting and Inservice Agenda dated 06/20/14, revealed a bullet list which included construction on drive. There was no written information in the inservice for reference. There were twenty-eight (28) signatures listed for the inservice out of one hundred and fifty (150) employees in the facility. Interview with the Administrator on 06/30/14 at 7:00 PM, revealed she started at the facility on 05/15/14, and was told by the previous Administrator there would be construction which included replacing damaged pavement on the west or back side of the building. She stated during the morning meetings she discussed the construction project with the managers; however, they did not discuss the safety aspects related to the construction. She stated in hindsight she should have ensured there was a new emergency evacuation plan specifically addressing the three (3) exits affected during the construction, as well as, formal inservicing and education of staff related to which doors were affected related to

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0518 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 35) construction and which doors were to be used for alternate routes. Further interview with the Administrator and previous Administrator on 07/01/14 at 12:00 PM, revealed it would be very important for staff to be aware of which doors led to the construction zone in order to ensure those doors were not used in the case of an emergency evacuation. The facility was unable to provide documented evidence they had developed and implemented a revised emergency evacuation plan specific to address the three (3) exits involved in construction. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following: 1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating DO NOT USE were also placed on the affected doors. 2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacutation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff. 3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14. Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified. 4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that Construction is in progress. Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits that stated, STOP-DO NOT USE by the Maintenance Director on 06/30/14. 5. The Medical Director was notified of the IJ 07/01/14 by the DON. 6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to STOP-DO NOT USE. The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14. 7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors Construction is in process. The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all temporarily closed evacuation exits saying STOP-DO NOT USE remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed. 8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct spot checks of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator. 9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use. The State Agency validated the implementation of the facility's AOC as follows: 1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM. Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction. 2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice. Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding. Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person. Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency. 3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes. Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14. Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans. Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes. Interview with the SSD on 07/02/14 at 2:37 PM,

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F 0518 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 36) revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education. 4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged. Observation, on 078/02/14 at 11:32 AM, revealed signs stating STOP-DO NOT USE were posted on the temporarily closed evacuation exits. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM. 5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14. 6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director. 7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the STOP-DO NOT USE signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log. 8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing spot checks of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her. 9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator. Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party.
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a K. After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY 980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a K. Based on observation, record review, interview, review of the facility's policy and Evacuation Plan, during the 07/03/14 survey, it was determined the facility failed to have an effective system to identify a Quality Assurance (QA) concern, and develop and implement appropriate plans of action. The facility's QA system's failure to develop and implement appropriate plans of action prevented the facility from ensuring effective measures were in place for appropriate evacuation of residents from the Northwest and Southwest hallways and dining room in case of fire or other emergencies, due to the exits not being accessible related to construction. The primary emergency exit routes for the Northwest and Southwest Hallways were the exits at the end of the hallways leading outside per the facility's evacuation plan; however, observation revealed those were the exits inaccessible due to the construction. This could potentially affect sixty (60) residents out of the facility's one hundred and twenty-four (124) residents in the event of an emergency evacuation. In addition, the map posted in the dining room revealed arrows leading to the outside exit, as the emergency exit route from the dining room. Observation revealed there was construction outside the dining room door exit. The facility's QA system failed to identify, develop and implement plans of action to address: the construction outside the facility leaving the three (3) emergency exit doors without a safe path to a public way; the need for a revised evacuation plan in the case of a fire or other emergency related to the three (3) emergency exit doors; and the need to ensure staff was trained and knowledgeable of which fire exits were appropriate for evacuation during the construction. (Refer to F-323, F-490 and F-518) The facility's failure to develop and implement an evacuation plan during construction which affected fire/emergency exits was likely to to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 06/30/14 and determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at 42 CFR 483.75 Administration at a Scope and Severity of a E, while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure the residents' environment remains as free of accidental hazards as was possible; and each resident receives adequate supervision to prevent accidents. Based on observation, interview, record review, review of the facility's policy and investigation reports and call light audits, during the 08/01/14 survey, it was determined the facility failed to have an effective system to develop and implement appropriate plans of action to ensure resident grievances were acted upon and resolved regarding call light issues. (Refer to F-166) The findings include: Review of the facility's, Performance Improvement Plan Policy, dated February 2009, revealed it was the intent of the facility to conduct an ongoing performance improvement program designed to: systematically monitor and evaluate the quality and appropriateness of resident care; pursue opportunities to improve resident care; resolve identified problems; and identify opportunities for improvement in a timely manner. Further review revealed the Performance Improvement (PI) Committee and the facility would use the risk management approach to establish key quality indicators designed to monitor effectiveness of established systems across departments. Reference F-323, F-490, F-518 1. Review of the facility's, Disaster Preparedness Manual, dated January 2005, revealed the fire safety procedure plan noted when preparing for an evacuation when the fire alarm was sounded the primary exit route should be checked first, and if this exit was safe and clear staff should use that exit if evacuation was ordered. Review of the facility's, North Nursing Department Fire Emergency Guidelines and South Nursing Department Fire Emergency Guidelines, both undated, revealed staff was to check the primary exit route and if it was blocked they were to use the secondary route. Observation of the maps posted across from the nurse's station on the North and South units on 06/30/14, revealed the maps had arrows pointing towards the exit doors at the end of the Northwest and Southwest hallways leading to the outside indicating those doors were an exit route. Additionally, review of the map posted in the dining room on 06/30/14, revealed arrows leading from the dining room to the exit door, which led outside the building, as an exit route from the dining room. On 06/30/14 at 2:20 PM, interview with the Director of Plant Operations revealed on 06/24/14 construction started with removal of the concrete pavement outside of the Northwest hallway and the dining room exit, and on 06/27/14 the concrete pavement was removed outside the Southwest hallway exit door. The Director of Plant Operations stated he was not aware of the facility having a revised evacuation

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 37) plan related to construction. He stated staff, including himself, had not received any formal training related to a new evacuation plan due to construction, even though those three (3) exits were not accessible in case of an emergency evacuation because of the construction. Observations on 06/30/14 from 5:15 PM until 5:24 PM of the dining room exit door revealed a concrete pad leading to a three and a half (3.5) inch drop off which led to rebar (steel bar used in construction to reinforce concrete) and gravel. Observation of the Northwest hallway exit door revealed a ramp leading to a three (3) inch drop off to gravel and rebar. Additionally, observation of the Southwest hallway exit door revealed a ramp leading to a four and a half (4.5) inch drop off to gravel. Interview, on 06/30/14 at 5:05 PM and 07/03/14 at 7:00 PM, with the Director of Nursing (DON) revealed on 06/17/14, she was told construction would be starting on 06/18/14 and they were told to stay clear of the exit doors to the Northwest and Southwest hallways exits because the sidewalks were being replaced outside those doors. However, she had not been educated as to the alternate routes to use for emergency evacuation due to those exits being inaccessible. The DON stated it would be important for the facility to have an alternate evacuation plan and ensure staff were inserviced on this because staff would be unable to get wheelchairs out the exits by the construction. According to the DON, she did not remember bringing up any safety concerns related to the construction in the last QA Meeting. She further stated the facility had no QA Nurse, and all the department heads were responsible for bringing their audits and tracking and trending related to their departments to the QA meetings to discuss findings. Interview with the Staff Development Nurse (SDN) on 06/30/14 at 5:30 PM, revealed she was aware there was construction taking place outside the building as new concrete was being put on the driveway in the back of the building. She stated she was told staff could not use the exits at the back of the building including the dining room exit and she had provided a verbal inservice to some staff, on 06/20/14, related to the construction and which exit doors to use for an emergency evacuation. However, she was unaware there was construction near the Northwest hallway exit door and had not inserviced staff related to the door being inaccessible. She stated she was unaware of the facility having any new formal evacuation plan in case of fire or other emergency prior to or since the construction began. Interview, on 06/30/14 at 7:00 PM, with the Administrator revealed she had been informed on 05/15/14, by the previous Administrator, construction was to begin on 06/17/14 to include replacement of damaged pavement on the back side of the building which was the west side. She stated however, the construction was delayed and did not start until 06/24/14. Per interview, the Administrator had discussed the construction would consist of taking up the old concrete and re-pouring concrete at the back of the building every few days in the morning meetings. However, she stated during those morning meetings they had not discussed any safety aspects related to the construction. The Administrator explained the facility evacuation plan stated if for some reason an exit could not be used, staff were to use another exit; but she stated if all staff was not aware they could not use certain fire exit doors, this could cause a delay in getting residents evacuated from the building in an emergency situation. The Administrator indicated this was her first time having construction in a building as Administrator and therefore, had not thought about needing a new emergency evacuation plan for the facility. She stated in hindsight though she should have ensured there was a new emergency evacuation plan specific to address the three (3) emergency fire exits not available for use during the construction. Per interview the Administrator revealed the last QA meeting was 06/18/14, prior to the initiation of construction. She stated she had told the QA Committee in that meeting, construction was getting ready to start. The QA Committee had discussed the construction; however, they had not identified or discussed any safety aspects related to the fire exit doors which would be inaccessible during the construction. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following: 1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating DO NOT USE were also placed on the affected doors. 2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff. 3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14. Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified. 4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that Construction is in progress. Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits that stated, STOP-DO NOT USE by the Maintenance Director on 06/30/14. 5. The Medical Director was notified of the IJ 07/01/14 by the DON. 6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to STOP-DO NOT USE. The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14. 7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors Construction is in process. The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all temporarily closed evacuation exits saying STOP-DO NOT USE remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed. 8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct spot checks of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator. 9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 38) are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use. The State Agency validated the implementation of the facility's AOC as follows: 1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM. Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction. 2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice. Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding. Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person. Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency. 3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes. Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14. Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans. Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education. 4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged. Observation, on 078/02/14 at 11:32 AM, revealed signs stating STOP-DO NOT USE were posted on the temporarily closed evacuation exits. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM. 5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14. 6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director. 7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the STOP-DO NOT USE signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log. 8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing spot checks of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her. 9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator. Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party. Reference F-166 2. Review of the facility's policy titled, Investigating a Resident Grievance or Complaint, dated December 2010, revealed grievances and/or complaints would be investigated and recorded on the grievance/complaint log. The Policy noted the Administrator would assign the responsibility of investigating grievances and complaints to the Social Services Director (SSD) or designee who would initiate an investigation. The policy revealed the investigation and report were to include a follow-up/recommendation for corrective action, a resolution, date of the resolution and was to be reviewed by the Administrator within three (3) working days of the facility receiving the complaint/grievance. The Policy stated the resident or responsible party was to be notified of the findings. Review of the Resident Council Minutes for April, May, June and July of 2014 revealed the residents had complained of their call bells not being answered timely in the past two (3) months. Interview with residents during the Group Interview and also individual resident interviews revealed they continued to complain of their call bells not being answered timely. However, review of the facility's documentation regarding grievance forms and call light audits revealed no documented evidence the facility had attempted to resolve the residents' grievances regarding call bells, until 06/03/14, even though this had been an ongoing concern expressed by residents since April 2014. Interview with the SSD, on 07/03/14 at 4:08 PM and on 07/25/14 at 7:20 PM, revealed to address the Resident Council's concerns related to their call lights not being answered timely, she developed an audit for call lights to be performed across all shifts and during shift changes. The SSD indicated the call light audits had been initiated a few months ago. Per interview, on 07/03/14 at 3:42 PM, with the Activities Director, with Registered Nurse (RN) #4/Assistant Director of Nursing (ADON) at 4:35 PM, and at 6:41 PM with the Staff Development Coordinator (SDC) revealed call light audits were being conducted on all shifts. The Activity Director stated residents had voiced concerns in the Resident Council Meetings regarding staff taking a long time to answer their call lights, which were placed on grievance forms and given to the Social Services Director (SSD) to investigate. RN #4/ADON revealed the SSD was responsible for the audits of the call lights and the audits were supposed to be reviewed in the facility's Quality Assurance (QA) meetings. The June 2014 call light audits were reviewed and revealed only the 7:00 AM to 3:00 PM, and 3:00 PM to 11:00 PM shift had been audited. Continued review revealed no documented evidence of call light audits conducted on the 11:00 PM to 7:00 AM

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 39) shift. Further interview with the SSD, on 07/03/14 at 4:08 PM and on 07/25/14 at 7:20 PM, revealed call light audits had not been completed during the 11:00 PM to 7:00 AM shift because there were not a lot of complaints related to the night shift. She stated after becoming aware of problems regarding night shift on 07/03/14, after surveyor intervention, the call light audits had been initiated at that time on night shift. However, the SSD indicated the call light audits should have been done during night shift also, as the QA process had been for audits to be performed across all shifts. Interview, on 07/03/14 at 5:20 PM and 08/01/14 at 9:34 AM with the Director of Nursing (DON), revealed once a week administrative staff discussed with residents how the staff responsible for their care was doing with answering their call lights. The DON reported if a concern was identified, she would talk to residents more often regarding this. Per interview, the DON indicated residents' concerns were why the facility was continuing with the call light audits. She stated the facility had been aware of call lights being an issue related to Resident Council concerns and resident interviews which had been taken to the QA meetings and discussed. The DON stated when concerns were identified and taken to QA and audits implemented, and if the issue continued to be a concern, audits were increased. Per interview, she stated since most of the call light concerns had been related to evening shift and weekends the audits had been performed during those timeframe's, and stated the audits had been performed from the information we had. She reported the SSD analyzed the findings of the call light audits and looked for patterns on when it took longer for staff to answer the call lights. Interview, on 07/03/14 at 7:25 PM, with the former Administrator and on 07/31/14 at 10:14 PM revealed she had not attended the facility's June 2014 Quality Assurance (QA) Meeting. She stated the facility was conducting call light audits when she became Administrator, and she knew call lights were an issue in the Resident Counsel Meetings. However, the Administrator reported she was not sure if the call light audits were being conducted on night shift. The Administrator indicated the audits may have been more effective if the time it took for each call light to be answered was the focus, instead of looking at the average time for a call light to be answered. She did not think the current QA effort to improve the timeliness of answering call bells had been effective to correct the problem.