STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. BUILDING _____ B. WING _____	06/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - CAMELOT	1101 LYNDON LANE LOUISVILLE, KY 40222

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 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure emergency call light pull cords were accessible to the residents in three (3) of twenty (20) residents' bathrooms (Residents' rooms #121, #124, and #238). The findings include: Review of the facility's policy regarding Call Light, Use of, dated 2006, revealed the facility was to ensure the emergency call lights were in functional order and conveniently accessible for the resident to use. The facility staff was to notify the Maintenance Department and enter the defective call light locations in the maintenance log. Review of the facility's policy regarding, Building Engines, Work Order Submission Guidelines, dated May 2004, revealed employees of the facility placed maintenance requests into the computer program called the Building Engines'. Review of the Non Clinical Rounds checklist, dated May 2007, revealed the administrative staff was to inspect the call lights to ensure they were in reach for all residents. Additionally, the checklist indicated staff would enter any maintenance issues into the Building Engines Maintenance System. The checklist instructed the staff to give a copy of this checklist to the Housekeeping Supervisor and to turn the sheet in to the Administrator. Observation, on 04/21/15 at 12:55 PM, revealed the emergency pull cord call light located in the shared bathroom of resident rooms 124/125 was located behind and above the toilet. The cord hung down behind the tank of the toilet. Further observation revealed the end of the pull cord was caught on the tank of the toilet. Observation, on 04/21/15 at 1:00 PM, revealed the emergency pull cord call light located in the bathroom of resident room [ROOM NUMBER] was located behind and above the toilet. The cord was short, hanging down to only approximately three and one half (3 ½) feet above the floor. The resident would have to stand up or turn around and reach behind them to grasp the cord. Observation, on 04/21/15 at 2:15 PM, revealed the emergency pull cord call light located in the shared bathroom of resident rooms 238/239 was wrapped around the grab bar several times. The emergency call light cord could not be activated by pulling on the emergency pull cord. Interview with Certified Nursing Assistant (CNA) #5, on 04/22/15 at 2:15 PM, revealed she goes and looks around resident rooms, bathrooms, and shower rooms periodically to look for hazards. However, there was no system currently in place to dictate when or how often nursing staff would check these areas. Interview with the Alzheimer's Care Unit (ACU) Manager, 04/23/15 at 11:00 AM, revealed she did not monitor the emergency pull cords in the residents' bathrooms to ensure they were functioning or, for the appropriate placement of the cords. The Unit Manager stated she did not instruct the CNAs to check or monitor the emergency pull cords. The Unit Manager stated the administrative team checked the rooms weekly for hazards and cleanliness, but she did not know what the process was or if the administrative team checked the pull cords. Interview with Maintenance Director, on 04/23/15 at 3:50 PM, revealed the facility had no current audit system to ensure the functioning and placement of the pull cords themselves. The Maintenance Director stated the facility had an electronic emergency system that checked periodically to ensure the emergency system was functioning. The Maintenance Director stated the administrative team checked the rooms weekly for any maintenance or housekeeping issues, as well as, call lights in reach and functional, and that the resident had water. Each member of the administrative team inspected four (4) to five (5) rooms weekly. The administrative staff looked at the integrity of each room including the call lights to ensure they were within reach. Interview with the Administrator, on 04/24/15 at 11:40 AM, revealed the facility did not have a policy for checking emergency pull cords and emergency lights. The Administrator stated the facility had an electronic system that indicated when there was a problem with the emergency system. However, the Administrator stated there was no schedule in place for staff to make rounds to check the function of the pull cords, or to ensure their proper placement and functioning. Interview with the Maintenance Director, on 05/06/15 at 1:25 PM, revealed the facility had a checklist that itemized what the administrative staff looked at during their rounds. However, most of the administrative staff did not use the checklist anymore. He stated he no longer used the checklist. The Maintenance Director reviewed it and stated that was the first time in a long time he had looked at the checklist. He further stated there were items on the checklist he had forgotten to check during his weekly room rounds. Further interview revealed the facility placed all items on this list for a purpose and they were important items to look at during their weekly room rounds. With the weekly room rounds, each member of the administrative staff had 3-4 rooms that they monitored weekly. Interview with the Administrator, on 05/07/15 at 1:45 PM, revealed many of the administrative staff did not use the checklist to complete weekly room rounds. The Administrator stated he provided the checklist to the administrative staff to complete room rounds. He stated many of the staff do not actually write on the form, but are supposed to use it as a guide. Further interview with the Administrator revealed many of the administrative staff had done room rounds for a long time and believed the staff was aware of what items to look for during room rounds. He stated they may not have used the checklist while completing the room rounds.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure a sanitary environment for all residents for two (2) of two (2) wings. Observations of the West Wing revealed three (3) of four (4) shower rooms were unsanitary. The piano was sticky and dusty. Resident rooms #128, 129, and 139 had mattresses on the floor that were soiled. The bathtub in room 121 had black particles. The bathrooms between resident rooms #136, 121, 108, 123, 115, 117, 116, 126, 125, 106, and 147 had heavy soiled floors. Room #108 had soiled washcloths on the resident's sink. Observation of the East Wing revealed three (3) of three (3) shower rooms were unsanitary. Room #210 had an extremely strong odor of urine. The dining room in the Alzheimer's Care Unit (ACU) had food debris on the chairs and tables for several hours after meals. The common area in the ACU had a heavy build-up of dust on the ceiling, walls, and fan. The couch on the Advanced Alzheimer's Care Unit (AACU) had a brown substance with residents sitting on top of the stain without staff interventions. The corner wall by the nurses' station had chunks of drywall missing and was dirty. The findings include: Review of the facility's Housekeeping Manual, undated, revealed the Housekeeping Department must provide the residents with clean and sanitary surroundings. Review of the facility's policy titled, Cleaning and Disinfecting Residents' Rooms, dated 12/01/14, revealed the facility would clean surfaces such as floors and tabletops on a regular basis, when spills occurred, and when these surfaces were

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

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F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) visibly soiled. Review of the facility's Building Engines Work Order Submission Guidelines, dated May 2004, revealed employees of the facility placed maintenance requests into the Building Engines' computer program for completion. Review of the facility's Housekeeping In-service guidelines on floor care, dated January 2000, revealed the facility's housekeeping staff was to sweep and mop all ceramic tile daily. Review of the facility's Housekeeping In-service guidelines on 7-Step Daily Washroom Cleaning, dated January 2000, revealed the proper method to sanitize a washroom or bathroom in the facility on a daily basis. Further review revealed, Housekeeping would check supplies to ensure toilet paper, paper towels, and soap dispensers were full, and then empty the trash and dust mop the floor. Housekeeping staff would clean and sanitize the commode, spot clean the walls, and then mop the floor last. Review of the facility's Housekeeper Routines, undated, revealed each of the four (4) housekeepers cleaned the shower rooms each morning between 7:00 AM and 8:15 AM. Each of the four (4) housekeepers conducted a walk through on their units at least twice per day and cleaned the residents' rooms once per day. Observations, on 04/21/15 at 9:00 AM, of the shared bathrooms for resident rooms 133/134, 131/132, and 129/130 revealed the bathroom floors were soiled with loose particles on the floor. Observations, on 04/21/15 at 12:55 PM, revealed the West B Hall shower room had a strong odor of feces. The toilet had brown splatters in it and the shower room had no paper towels. The soiled linen carts were filled to the top with soiled clothing and linen. Observations, on 04/21/15 at 1:00 PM, revealed the West Hall shower room on the ACU had a strong odor of feces. A wet washcloth was observed on the floor in the shower stall. The soiled linen carts contained a cloth container, with a plastic bag on the inside. The cloth container was unzipped and filled to the top; however, the plastic bag was bulging from the zipper, and the lid was able to close. Continued observation, on 04/21/15 at 4:15 PM, revealed the West Hall shower room on the ACU continued to have a strong odor of feces and had brown smears and spots on the toilet bowl. Observation, on 04/22/15 at 7:45 AM, revealed the shower room on the ACU hallway contained a linen cart that was filled to the top of the cart. Observation also revealed feces on the toilet seat and in the toilet. Observations, on 04/21/15 at 1:05 PM, revealed the shared resident bathroom for rooms 228/229 had feces on the back of the toilet seat. Further observation of the shared bathroom for resident rooms 228/229, on 04/21/15 at 3:45 PM, revealed feces remained on the back of the toilet seat. Observation of the shared bathroom for resident rooms 228/229, on the following day, 04/22/15 at 7:50 AM, revealed the toilet had feces on the surface of the seat and the back of the toilet seat. Observations, on 04/21/15 at 1:15 PM, revealed the West Hall shower room on the AACU had a strong odor. The soiled linen carts were filled to the top with soiled clothing and linen. The trash cans were full and spilling onto the floor. Used paper towels and four (4) soiled gloves were observed on the floor. Observations, on 04/21/15 at 1:25 PM, revealed the shared resident bathroom for rooms 136/135 had a toilet that contained a brown substance in the toilet bowl. The bathroom had a strong odor of feces. Observations, on 04/21/15 at 1:30 PM, revealed the East D Hall shower room contained an over filled linen cart and over filled trash can. The shower room had a strong lingering, unpleasant odor that smelled like feces. The shower chair contained dried brown spots and smears on the shower chair seat. Observations, on 04/21/15 at 1:40 PM, revealed the East A Hall shower room contained an over filled linen and trash cart. Trash was spilling out onto the shower room floor. The shower room had a strong unpleasant odor that smelled like feces. Observation of resident room 210, on 04/21/15 at 3:52 PM, revealed the room contained an extremely strong odor of urine. The resident was in the room lying in the bed with his/her eyes closed and covers pulled up. Observation of resident room 210, on the following day, 04/22/15 at 10:30 AM, revealed the room continued to have a very strong urine odor. Observation of the dining room on the ACU Hall, on 04/21/15 at 2:40 PM, revealed the tables and chairs contained food particles on them. Eleven (11) of the fifteen (15) chairs in the dining room were visibly soiled with white and pink spots, crumbs, and red and orange particles of food on the seats and/or hand rests. Three (3) of three (3) tables in the dining room had a buildup of food on the edges of the tables. Observation, on 04/22/15 at 7:30 AM, of the dining room on the ACU hallway revealed crumbs and food stains on the chairs in the dining room. The facility had not yet served breakfast on the ACU hallway at the time of this observation. Observation, on 05/05/15 at 11:30 AM, revealed the outer corner of the nurses' station in the common area of the ACU hallway had a large dent and chunks of drywall missing. The damage in the wall ran from the floor to the handrail approximately 1.5 inches on either side of the corner. The rubber floor boarder was peeling away from the wall. Observation, on 05/05/15 at 11:30 AM, revealed a chair in the ACU hall in the common area had a whitish substance on the seat of the chair and running down the front of the seat of the chair. At 1:00 PM, the chair continued to have this whitish substance on it. Interview with Housekeeper #1, on 04/22/15 at 8:50 AM, revealed housekeeping staff do not use a task list to assist with managing their cleaning schedules. Housekeeper #1 stated he did receive a task list as a new employee of the facility, but no longer used the task list. Housekeeper #1 stated he did a walk-through of his area two times per day in addition to cleaning each room and the common area. He stated during his walk through, he pulled trash and checked paper supplies. The housekeeper stated if he found a large mess, he would clean it at that time. Housekeeper #1 stated that, because of the size of the area, he must clean each area in five (5) to ten (10) minutes in order to have cleaned all of the rooms. He further stated nursing staff would call the Housekeeping Department to report any housekeeping needs that came up after the housekeeper had left the area. Housekeeper #1 stated he observed food particles on the furniture in the dining room and stated the food would be from dinner the previous evening. He stated he was responsible for cleaning the dining rooms after breakfast and lunch, but that it may take a while because there were three (3) dining rooms to clean. He stated an employee from laundry cleaned the dining rooms after dinner. Housekeeper #1 stated staff had not thoroughly cleaned the dining room after dinner the previous evening based on what he observed. Interview with Housekeeper #2, on 04/22/15 at 10:30 AM, revealed she had not talked with the nursing staff about assisting the resident in room 210 out of the room so she may clean the room. Housekeeper #2 stated she would work around a resident if a resident was in their room. The housekeeper stated the strong odor could potentially be a dignity issue or a health issue for the resident. Further interview with Housekeeper #2 revealed she did not clean a mattress unless it was a deep cleaning day or nursing staff or the housekeeping supervisor instructed her to clean the mattress. Housekeeper #2 also stated she swept and mopped the residents' bathrooms and shower rooms daily. Interview with Certified Nursing Assistant (CNA) #5, on 04/22/15 at 2:15 PM, revealed residents on the ACU hallway go into the shower rooms to use the toilet or wash their hands independently. The CNA stated she checked resident rooms, bathrooms, and shower rooms periodically to look for hazards and messes. However, there was no system currently in place to dictate when or how often nursing staff would check these areas to ensure toilets and bathrooms remained clean and sanitary. The CNA stated if nursing staff find feces, they clean it up and then report it to housekeeping to sanitize the area. Interview with the ACU Manager, on 04/23/15 at 11:00 AM, revealed nursing staff checked resident shower rooms and bathrooms two (2) to three (3) times per shift to ensure there were no hazards and to ensure the areas were sanitary. The Unit Manager stated there was a checklist or procedure in place to ensure nursing staff did these room checks. Interview with the Housekeeping Supervisor, on 04/23/15 at 4:30 PM, revealed the facility employed housekeeping through a contract. The Housekeeping Supervisor staffs the facility with two (2) housekeepers on the East side of the facility; two (2) housekeepers on the West side of the facility; and, a Floor Technician. The Housekeeping Supervisor stated housekeeping removed trash and linens each morning and after lunch each day. Interview with the Housekeeping Supervisor, on 04/24/15 at 9:10 AM, revealed the facility informed her of any housekeeping needs at the morning meeting. The Housekeeping Supervisor stated the four (4) housekeepers and one (1) floor technician for the facility could complete all tasks and maintain a clean and sanitary environment. The Housekeeping Supervisor stated she supervised the housekeeping staff by inspecting the facility daily during the day. She was not in the building to supervise the housekeeping in the evening. The Supervisor stated the housekeepers could keep up with their work tasks. The Housekeeping Supervisor also stated the housekeepers cleaned the dining rooms as soon as each meal was completed. The ACU and AACU have three (3) dining rooms and may take slightly longer. The Housekeeping Supervisor stated after dinner, one of

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F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) the laundry staff cleaned the dining rooms. The Housekeeping Supervisor stated the facility communicated any housekeeping issues to her during the morning meeting. Further interview with the Housekeeping Supervisor revealed discussion of room 210, which had a strong odor of urine. The Supervisor stated she had instructed the housekeeper to ask nursing to let her know when the resident was out of the room so that she could clean the room. The Supervisor stated the housekeeper cleaned the shower rooms one (1) time per day and checked them three (3) times per day. Additionally, she stated if nursing discovered a mess, they should call housekeeping and let them know. The Supervisor stated on her inspections, she had found areas where the housekeeping staff had not adequately cleaned and if the staff did not clean areas properly, it could potentially lead to infection. Interview with the Housekeeping Supervisor, on 05/06/15 at 1:50 PM, revealed there was no specific policy for cleaning the common areas. She also could not provide a policy on cleaning the furniture. She stated she had furniture cleaned after observing a soiled piece of furniture or cleans them after nursing reported soiled furniture to housekeeping. If nursing had any housekeeping issues, they would have communicated it to the Housekeeping Supervisor in the morning meeting. The Housekeeping Supervisor stated she conducted walk-throughs of the facility. She stated she did not look up and notice the dust on the ceiling fans and walls. She stated she cleaned the furniture as needed Interview with the Maintenance Director, on 04/23/15 at 3:50 PM, revealed the administrative staff made room rounds and checked rooms weekly for maintenance and housekeeping concerns. Each member of the administrative staff checked three (3) to four (4) resident rooms. They go into the rooms weekly and look for issues pertaining to pull chords, maintenance issues, housekeeping issues, and other room needs. If there are issues, the administrative staff discussed those issues in the morning meeting. If members of the administrative staff find a maintenance issue, the process is they are to place a work order in the Building Engines Program in the computer. The Building Engines produces the work orders for maintenance at least daily. Interview with the Maintenance Director, on 05/06/15 at 1:25 PM, revealed there was a checklist for Non Clinical Rounds, updated May 2007. The facility developed the checklist so the administrative staff would know what to look for in their assigned rooms. The Maintenance Director stated the walk around included resident rooms, but common rooms and areas were not included with the weekly administrative walk through. He stated he does have a monthly walk through of the entire building in the routine maintenance in Building Engines. The Maintenance Director stated he no longer used the checklist for Non Clinical Rounds. The Maintenance Director stated many of the administrative staff had been doing the inspections so long they no longer used the checklist. After reviewing the checklist, the Maintenance Director revealed he had forgotten some of the items on the checklist. He stated all of the items on the checklist were important. Interview with the Administrator, on 05/07/15 at 1:45 PM, revealed many of the administrative staff no longer used the checklist to complete weekly room rounds. The Administrator stated he provided the checklist to the administrative staff to complete room rounds. He stated many of the staff do not write on the form, but are supposed to use it as a guide. The Administrator stated that many of the administrative staff have done room rounds for a long time and they know what items to look for during room rounds. They may not use the checklist while completing room rounds. 3. Observation of the AACU, on 05/05/15 at 11:07 AM, revealed the green couch in the common area had smears of brown substance. No resident was sitting on the couch at this time. At 11:18 AM, the Speech Therapist assisted a resident to sit on the green couch in the exact spot where the brown substance was located. The resident remained on the soiled spot during the therapy session. Observation of the couch, on 05/05/15 at 4:32 PM, revealed a clean white blanket had been placed on the couch. Observation revealed the stain had been cleaned under the blanket. Resident #14 stated a professional cleaner had come into the unit to clean the couch and it was still wet. She stated the housekeeper had placed the blanket over the wet spot so the residents could sit on the couch and not get their clothes wet. 4. Observation of the ACU's common area, on 05/05/15 at 11:07 AM revealed a ceiling fan with heavy build-up of dust hanging off the blades. A small table where snacks were served to residents was within three (3) feet of the fan. In addition, a heavy build-up of dust and dirt was noted on the ceiling and walls surrounding the ceiling fan. Interview with the Housekeeping Supervisor, on 05/06/15 at 1:55 PM, (in the ACU common area to observe the areas of concern) revealed she had not noticed the ceiling fan and surrounding area with the heavy build-up of dust. She stated she conducted walking rounds on the units, but she did not look up and see the dust on the ceiling fan, ceiling, and walls. She stated she had not cleaned the ceiling fan or walls since she had been in this position, two (2) months. Continued interview with the Supervisor revealed she observed the brown substance on the couch in the AACU's common area yesterday (05/05/15) and cleaned the spot. She stated the furniture on the units get stained often because the residents eat and drink in those areas. She stated no facility staff had reported the stain. Further interview revealed she made rounds several times a day to ensure the facility was clean and she always looked at the furniture to see if there had been any spills that needed to be cleaned. She revealed there was no specific policy for cleaning of the common areas in the units. 5. Observation of the East Wing, on 04/21/15 at 4:20 PM, revealed the piano in the dining room was covered with multiple overlapping and independent sticky base of cup rings and small particles of brown, white and a dust-like substance. Observation of the bathrooms on the East Wing, on 04/21/15 at 9:45 AM, revealed bathroom floors in Rooms 115, 116, 117 and 126 were heavily soiled with a black substance. In addition, the Shower Rooms on the B, C and D Halls had soiled sticky floors. Observations of the bathroom floors on the East Wing, on 05/05/15 at 8:21 AM, revealed heavily soiled bathroom floors in rooms 136, 121, 108, 123, 115, 117, 116, 126, 125, 106 and 147. Observations of resident rooms 128, 129, and 139, on 05/05/15 at 8:27 AM, revealed the residents had mattresses used as fall mats. These mattress were soiled and had cracks and torn corners. Observations of the shower rooms on the East Wing, on 05/05/15 at 8:40 AM, revealed three (3) of the four (4) rooms had soiled sticky floors. The C Hall whirlpool tub stretcher mat was torn in three (3) places and was covered in a white substance. There were soiled paper towels on the floor and soiled wash cloths on the floor. Interview with the Housekeeping Manager, contracted by the facility, on 05/06/15 at 1:06 PM, revealed she was aware of the condition of the bathroom floors. She stated she had not informed the Administrator regarding the floors. Further interview revealed she was not sure how the floors became so soiled since she had only been a manager for two (2) months. She stated the floors were too soiled and needed to be scrubbed with a machine first.
F 0280 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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 observation, interview, record review, and facility policy review, it was determined the facility failed to ensure residents' care plans were reviewed and revised after behaviors and falls were noted, for six (6) of twenty-nine (29) sampled residents, (Resident #1, #6, #10, #11, #12 and #29). The facility was aware of Resident #10's history of sexual acting out (SAO) behaviors and care planned the resident to be monitored. On 03/11/15, the resident was not supervised and was found by staff engaging in sexually inappropriate behaviors with another resident. The resident was sitting on a couch, on the secured unit, with another resident sucking on the other resident's breast. The facility failed to revise the care plan to include adequate supervision to monitor the resident for continued SAO behaviors and staff intervention. In addition, Residents #1, #6, #11, #12 and #29 had injurious falls and their care plans were not revised to prevent further falls. Resident #6's risk for falls care plan was not revised with interventions related to the resident laying his/her head in his/her lap and leaning forward or laying himself/herself down on the floor. Resident #1 sustained multiple falls without revision to the care plan to prevent further falls. Resident #29 had a history of [REDACTED]. However, the facility failed to revise the care plan to reflect the current mode of transfer for staff to follow. Resident #12 had a fall which resulted in a Subdural Hematoma that required hospitalization ; there was no revision to the care plan. Resident #11

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) sustained three (3) falls associated with going to the bathroom. The facility failed to determine the root cause and revise the care plan to address assistance when going to the bathroom. The facility's failure to have an effective system in place, to ensure care plans were revised for residents with behaviors and falls, was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 03/11/15. The facility was notified of the Immediate Jeopardy on 04/24/15. An Acceptable Allegation of Compliance (AOC) was received on 04/29/15 which alleged removal of the Immediate Jeopardy on 04/29/15. The State Survey Agency (SSA) determined the Immediate Jeopardy was not removed on 04/29/15, as alleged; the SSA determined the Immediate Jeopardy was removed on 05/07/15. The Scope and Severity was lowered to a D while the facility implements and monitors the plan of correction for the effectiveness of the systemic changes and quality assurance. The findings include: Review of the facility's policy regarding Condition Change of the Resident (Observing, Recording and Reporting), dated 01/26/15, revealed the facility was to compare the resident's condition to his/her previous level of functioning. Additionally, the facility would identify the underlying problems causing the condition change and establish a measurable goal and plan to treat the condition including preventative and safety measures. Review of the facility's policy regarding Behavior Management Guidelines, dated 02/12/15, revealed the facility was to develop behavior plans and medication regimens to optimize the functional abilities of residents while monitoring for adverse side effects and improved behaviors. Review of the facility's policy, Falls, dated 11/13/14, revealed the facility would evaluate for causative factors including changes in the environment. The facility would identify if the care plan was updated and new approaches were implemented immediately to reduce the potential for falls to reoccur. Review of the facility's policy titled, Content of the Medical Record, dated 10/07/13, revealed the care plan described the care and treatment provided to the residents. The care plan ensured the resident attained or maintained the highest practicable physical, mental, and psychosocial well-being. The care plan included any care or treatment that would otherwise be required for the provision of quality care. The care plan must have reflected the immediate steps for each goal if the identification of these steps enhanced the resident's ability to meet the goal. The interdisciplinary team utilized the care plan goals to monitor resident progress or lack of progress and documented this information in the medical record. The facility developed additional documentation for behavior management, including a care plan for residents exhibiting negative behaviors, establishing a monitoring system for targeted behaviors, interventions for those behaviors, and medication effectiveness. Review of the facility's policy for Resident Assessment Instrument (RAI) Process, dated 11/28/13, revealed the facility was to adhere to all Centers for Medicare and Medicaid Services (CMS) regulations which were considered the definitive source in completion of the RAI process, including completion of the Care Area Assessments (CAA) and the development of the comprehensive plan of care. The facility would utilize the CMS RAI Manual for completion and compliance of the RAI process. 1. Observation of Resident #10, on 04/21/15 at 11:30 AM, revealed the resident was spending time in the common areas of the ACU in the facility. Resident #10 sat in the common area of the unit, stood and walked around the unit, then went into his/her room. The resident was able to state that he/she was doing well and was able to answer brief closed questions. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 04/08/12 with [DIAGNOSES REDACTED]. Review of Resident #10's Quarterly MDS assessment, completed on 12/23/14, revealed the facility completed a Brief Interview Mental Status (BIMS) examination. The facility assessed the resident to have a BIMS' score of eleven (11) out of fifteen (15), indicating the resident had moderate cognitive impairment. Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 04/13/15, revealed the facility assessed the resident as requiring only supervision or limited assistance to complete Activities of Daily Living (ADL). The resident was able to transfer and walk in the corridor with supervision only. Review of the Comprehensive Care Plan for Resident #10, dated 03/12/15, revealed the resident had a history of [REDACTED]. Review of the Progress Notes, dated 01/30/15 at 2:40 PM, revealed nursing staff documented they had placed Resident #10 on fifteen (15) minute checks due to increased behaviors and needing redirection of female residents. The record did not indicate what behavior the resident exhibited; what interventions staff used with the resident; or how long the resident would remain on fifteen (15) minute supervision checks. The facility did not include this information on the resident's behavior care plan. Review of the facility's Administrator's Stand-Up Meeting (morning meeting documentation), dated 02/02/15, revealed the facility did not add Resident #10 to the list of residents to discuss in the meeting. Review of the Psychiatric Consult/Follow-Up, dated 02/06/15, revealed the facility consulted with the Psychiatrist due to Resident #10 becoming more inappropriate with touching other residents and staff. The Consult further stated the resident had Dementia and Sexual Acting Out (SAO) behaviors. However, on 02/06/15 the care plan addressed an increase in high sex drive towards staff and residents, and the only intervention listed for 02/06/15 was medication changes for behavioral disturbances. The care plan did not provide the staff with interventions to address the actual behavior. There were no other interventions added to the care plan until after the incident of 03/11/15. Review of the Progress Notes for Resident #10, on 03/11/15 at 5:50 AM, revealed nursing staff made an entry into the Behavior Charting and noted Resident #10 was sitting in the common area sucking on the breast of Resident #18. The resident was upset and refused to leave the common area after the incident. Staff documented vital signs and reported the resident was calm within twenty (20) minutes of the incident. The care plan did not provide interventions for staff to ensure the safety of the residents. Interview with CNA #12, on 05/05/15 at 9:40 PM, revealed she was working on the AACU hallway giving care to a resident the morning of 03/11/15. The nurse was about to give nursing care to another resident on the AACU hallway. After a few moments, the nurse went back to the nurses' station for a needed item pertaining to the care she was giving. When she entered the nurses' station, she observed Resident #10 and Resident #18 sitting on the couch engaged in inappropriate behaviors. The nurse called for CNA #12 and separated the two (2) residents. The nurse called the night supervisor. The nurse and CNA assisted Resident #18 back to his/her room and Resident #10 stayed in the common area. The supervisor placed Resident #10 on one-on-one monitoring until the day shift came in to work. The CNA reported she and the nurse took turns sitting with Resident #10 throughout the remainder of the shift. CNA #12 stated Resident #10 had no further SAO behaviors that shift. However, review of the care plan revealed this information was not added. Review of the Verification of Investigation form for Resident #10, dated 03/11/15 at 5:50 AM, revealed staff observed Resident #10 sitting in the common area sucking on the breast of Resident #18, who was sitting next to him/her. The form stated staff immediately separated the residents for their protection and staff placed Resident #10 on one-on-one (1:1) supervision until he/she left the facility to go to the hospital. The facility staff did not complete the portions of the Verification of Investigation form labeled, Summary and Outcome of Investigative Findings, nor did the care plan reflect the interventions described in the report. Review of Resident #10's care plan, dated 03/12/15, revealed the facility initiated a care plan for behaviors that included inappropriate sexual behaviors toward staff and residents on 03/11/15. Review of the care plan for Resident #10, dated 03/12/15, revealed the facility updated the care plan on 03/12/15 and added three (3) interventions: place the resident on fifteen (15) minute checks when exhibiting behaviors; inpatient stay for psychiatric evaluation; and, allow the resident time to talk or answer questions about how he/she is feeling. On 03/24/15, the facility updated the care plan, adding the intervention of assessing the resident for inappropriate sexual behaviors and aggression. Interview with Certified Nursing Assistant (CNA) #5, on 04/22/15 at 2:15 PM, revealed Resident #10 had a history of [REDACTED]. The CNA stated she had to supervise Resident #10 around other residents as he/she had a history of [REDACTED]. Interview with the Alzheimer's Care Unit (ACU) Manager, on 04/23/15 at 11:00 AM, revealed Resident #10 had a history of [REDACTED].#10 had a history of [REDACTED]. The Unit Manager stated in order to increase monitoring of the resident, the nursing staff would put Resident #10 on fifteen (15) minute checks anytime he/she had SAO behaviors. The Unit Manager stated she had documented on Resident #10 on 01/30/15 that she had placed Resident #10 on fifteen (15) minute checks due to increased SAO behaviors. The ACU Manager further revealed that in the time leading up to the incident on 03/11/15, Resident #18, who also had SAO

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) behaviors, and Resident #10 were focused on each other. The Unit Manager stated the staff had to redirect both of the residents away from each other many times; however, because of cognitive problems, the residents would quickly forget the redirection and start to focus on each other again. The Unit Manager stated nursing did not document these redirections in the Progress Notes and there was no evidence of the behavior or interventions used for Resident #10 in the care plan. Interview with Registered Nurse (RN) #6, on 04/23/15 at 1:45 PM, revealed the Supervisor requested the RN to put Resident #10 on one-on-one supervision. RN #6 stated Resident #10 had a history of [REDACTED]. However, review of the record revealed this behavior was not placed on the care plan. Interview with Staff Development, on 04/24/15 at 8:30 AM revealed the facility reviewed the care plans in morning meetings and revised them as needed. Interview with the ACU Manager, on 04/24/15 at 10:30 AM, revealed the facility was aware Resident #10 had inappropriate sexually acting out behaviors prior to 03/11/15. The ACU Manager stated Resident #10 would try to touch others inappropriately and would try to walk other residents into his/her room. ACU Manager also stated Resident #10 had frequently touched staff on the buttocks. The Unit Manager stated the facility monitored residents when they had SAO behaviors by placing the resident on the 24-hour report and on fifteen (15) minute checks, usually for three (3) days. She stated staff had observed Resident #10 in another resident's room standing over the other resident. The ACU Manager stated the facility did not change or increase supervision on the unit after Resident #10 returned from the hospital. Interview with the Director of Nursing Services (DNS), on 04/24/15 at 10:30 AM, revealed staff had to redirect both the residents leading up to the incident on 03/11/15. The DNS stated night nursing staff print out any documentation typed into the computer and place it in the charts each night. The DNS reviewed the Progress Notes and stated she could not find documentation pertaining to staff redirecting Resident #10 leading up to the incident on 03/11/15. After reviewing the Psychiatric Hospital's Assessment, the DNS stated she was unaware of the behaviors reported under the section titled Current Presenting Problems. The DNS further stated the facility had not added staffing on the night shift after the incident on 03/11/15 to ensure supervision. She stated the facility continued to staff the ACU and AACU Halls with one (1) nurse and one (1) CNA for both units. Interview with the Psychiatrist, on 04/24/15 at 2:05 PM, revealed Resident #10 had a [DIAGNOSES REDACTED]. Because of this, staff must redirect the resident many times. Resident #10 would have periods of doing well and would then impulsively exhibit SAO behaviors. The Psychiatrist was aware of the incident on 03/11/15. Further interview revealed Resident #10 required redirection often because he/she could not remember. He stated the facility sent the resident for inpatient treatment because the interventions in place were not working or because the environment was not safe due to his/her behaviors. The Psychiatrist further stated that a BIMS' score of eleven (11) for Resident #10 was not a good indicator of cognition because a resident could have a reserve of knowledge and score well one day and not well on another day. However, functionally, the resident could not care for himself/herself and did not have the cognition to solve problems. Review of the care plan revealed this information was not added to the care plan. Interview with the Administrator, on 05/05/15 at 8:40 AM, revealed the facility did not use behavior logs to track and monitor resident behaviors prior to the incident on 03/11/15. The Administrator stated the facility started using behavior logs to document resident behaviors in April 2015. When a behavior happened, the Unit Managers were to document that behavior in the Progress Notes or SBAR (Situation, Background, Assessment, and Recommendation). The SBAR triggered the incident report. The Administrator stated the facility conducted morning meetings, Monday through Friday, to discuss various issues including resident behaviors. The facility placed residents on the Administrator's Stand-Up Meeting form to discuss in the morning meetings. On the weekends, the Charge Nurse conducted meetings with the supervisors. The facility also held weekly Behavior Meetings to review behaviors in order to track the behaviors and prevent reoccurrence. However, review of the care plan revealed the behaviors were not added. Interview with CNA #15, on 05/06/15 at 9:30 AM, revealed CNAs attended a huddle at the beginning of each shift to discuss changes to care. Nurses would give CNAs their assignments at that time. The CNA stated she did not get the opportunity to read the actual care plans. Interview with CNA #5, on 05/06/15 at 10:00 AM, revealed the CNAs and nurses on the unit had a huddle each morning by the nurses' station to discuss any resident changes or issues. Interview with Licensed Practical Nurse (LPN) #5, on 05/06/15 at 10:30 AM, revealed nurses did not usually update resident care plans, but they could. The LPN stated the administrative staff updated care plans in the morning meeting. After the morning meeting, the Social Worker would tell the nurses verbally of any changes to the care plans. This was a verbal conversation with no documentation of the communication. The Nurses update the CNA care plans, or assignment sheets. She further stated the nurses obtained the information for the assignment sheet from the care plans. The LPN stated she read the care plans about one time per month. She stated if something happened with a resident, such as a behavior, then she would look at the care plan to ensure there was a care plan for that incident. Further interview revealed the nurses instructed the CNAs on what to do when a resident has a behavior. However, review of the care plan revealed no documented evidence the behaviors were added on the care plan for Resident #10. Interview with the ACU Manager, on 05/06/15 at 11:00 AM, revealed staff was to notify the Unit Manager or Nursing Supervisor when a behavior happened. The ACU Manager also stated the facility updated care plans in morning meeting. When the facility updated a care plan in the morning meeting, they communicated the information to the ACU Manager via the Enhanced Start-Up Sheet. The Unit Manager received the Enhanced Start-Up Sheet daily and placed the information on the assignment sheets or, on the 24-hour report. Interview with the MDS Coordinator, on 05/06/15 at 2:30 PM, revealed she developed care plans when the facility admitted a resident. The MDS Coordinator used orders, hospital notes, assessments, and information gathered during a 72 hour meeting with the family to develop the initial care plan in the computer. She completed daily updates to the care plans based on the SBAR and behaviors. The MDS Coordinator also updated care plans when residents returned to the facility from a hospitalization or when having behaviors. If a resident was having behaviors, the Social Worker would bring the behavior to the morning meeting and the MDS Coordinator would update the care plan with new interventions. The MDS Coordinator stated the facility did not update the care plan for Resident #10 after nursing placed the resident on fifteen (15) minute checks for increased behaviors on 01/30/15. However, the facility updated the care plan for Resident #10 after he/she returned from the hospital on [DATE]. The updates included adding an intervention saying the facility would monitor for increased SAO behaviors and would assess for inappropriate sexual behaviors. She further stated nursing staff did not place the incident on the 24-hour report. The MDS Coordinator stated since the facility did not update the care plan at that time, the interventions in place when the incident on 03/11/15 took place did not make sense for Resident #10. The MDS Coordinator reviewed the interventions in place after the 03/11/15 incident and stated two (2) of the three (3) interventions put in place for Resident #10 were not appropriate interventions to prevent the reoccurrence of the resident's SAO behaviors. Interview with the DNS, on 05/06/15 at 3:15 PM, revealed the facility made no updates to Resident #10's care plan after increased SAO behaviors on 01/30/15. The DNS stated the nurses did not document on SAO behaviors for Resident #10 for 01/30/15. She stated she was aware Resident #10 had been having problems with inappropriate touching of staff because the staff had reported that to her. 2. Observation during the initial tour, on 04/21/15 at 8:45 AM, of Resident #6, revealed the resident was lying in a low positioned bed with a mattress on the floor parallel to the bed. The bed was placed with one side next to the wall. Interview with the LPN #1 during tour, on 04/21/15 at 8:45 AM, revealed Resident #6 was at risk for falls, and had a history of [REDACTED]. He stated Resident #6 was ambulatory before his/her fall and currently used a geriatric chair for mobility. Observation, on 04/21/15 at 1:00 PM, of Resident #6, revealed he/she was in the geri-chair seated in front of the television (TV). He/she was tilted back facing the TV. The resident wore blue foam boots on his/her feet with both feet placed on the foot rest of the geri-chair. There was a cushion between the resident's upper legs. Review of Resident #6's clinical record revealed the facility admitted the resident on 06/04/13, with [DIAGNOSES REDACTED]. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 11/11/14, revealed the facility assessed the resident as severely impaired for cognitive skills for daily decision making. The facility assessed the resident's functional status with transfers; walk in room and corridor, locomotion on and off the unit revealed self-performance required limited assistance and one (1) person physical assist with the identified activities. The MDS did not identify any

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) mobility devices in use. Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a Fall care plan, on 06/04/13, for at risk for falls related to the history of falls, receiving psychoactive medications, required limited assistance at times with ambulation and transfers due to an unsteady gait and balance. In addition, the facility revealed additional contributing factors that increased the risk for falls included severe cognitive impairment, poor safety awareness, [MEDICAL CONDITIONS], history of Transient Ischemia Attacks (TIA) and [MEDICAL CONDITION]. Further review of the care plan revealed interventions that included assist with ambulation as needed; and, keep environment well lit and free of clutter, these were initiated on 06/04/13. The facility revised the same interventions, on 03/06/14, including for the call light to be kept within reach; however, the call light may or may not be utilized related to the resident's cognition. Additional interventions included to ensure proper footwear was worn; observe for fall related side effects of medications and report to the physician, if the side effects interfere with the resident's daily functioning; observe for tremors and increased difficulty with ambulation related to Parkinson; and, administer [MEDICATION NAME] as ordered, these were initiated on 10/25/13 and revised on 03/06/14. Interview with the MDS Coordinator, on 04/24/15 at 3:45 PM, revealed upon review of Resident #6's care plans she determined the interventions added were the same interventions already in place for the revision completed on 01/19/15. She stated the interventions for Resident #6 were not individualized specifically to the resident. 3. Observation during the facility tour, on 04/21/15 at 8:47 AM, of Resident #12 revealed the bed was placed against the wall. He/she appeared to be sleeping and was wearing head phones. Observation, on 04/21/15 at 1:10 PM, of Resident #12 during the lunch meal in the dining room revealed the resident was seated in a wheelchair at the table. Observation of the posterior head revealed an area of bruising in the occipital area and into the nape of the neck area. The area of bruising was visible through the resident's hair. Review of Resident #12's clinical record revealed the facility admitted the resident on 03/06/15 with [DIAGNOSES REDACTED]. Review of the facility's admission record revealed Resident #12 was originally admitted , on 02/19/15, with an additional [DIAGNOSES REDACTED]. Review of Resident #12's Admission Minimum Data Set (MDS) assessment, completed on 03/13/15, revealed the facility assessed the resident via a Brief Interview for Mental Status (BIMS) at a fifteen (15) of fifteen (15), being cognitively intact. The facility assessed the resident's functional status of transfers, walking in the room and corridor, locomotion on the unit and off the unit required limited assistance (staff provide guided maneuvering) and one (1) person physical assist for support. Further review revealed the facility assessed the resident's balance during transitions and walking in the areas of moving from a seated to standing position; walking with an assistive device; turning around and facing the opposite direction while walking; moving on and off the toilet and surface-to-surface (transfer between bed and chair or wheelchair) as not steady and only able to stabilize with staff assistance. Review of the Care Area Assessment (CAA) for Resident #12, dated 03/13/15, revealed the resident had a history of [REDACTED]. The MDS Nurse included knowledge the resident experienced fatigue, urinary incontinence, urge incontinence, was legally blind, hearing impaired, and had generalized weakness that predisposed Resident #12 to a risk for falls. Review of the Comprehensive Care Plan for Resident #12 revealed the facility developed a care plan on 03/09/15, with the target date of 05/29/15. Problems on the care plan included at risk for falls, impaired cardiovascular status, constipation, adverse drug reactions, gastrointestinal distress, alteration in respiratory status, ineffective communication, dehydration and fluid maintenance, risk for injuries due to vision impairment, requiring some assistance in participation in activities of choice related to vision, and alteration in activities of daily living functioning due to resident requires assistance for completion of care related to hard of hearing, legally blind and diminished physical abilities. Interview with Family Member #2, on 04/22/15 at 12:50 PM, revealed Resident #12 had fallen at the facility and required hospitalization . Family Member #2 stated the resident hit his/her head at the time of the fall. Further interview revealed Family Member #2 requested an alarm for Resident #12 upon the resident's return from the hospital on [DATE]. Family Member #2 stated she again spoke with the nurse on 04/18/15 about the resident having an alarm to alert the staff when he/she was up and about without supervision. She reported, as of this day, the resident still did not have an alarm. Interview with Resident #12, on 04/23/15 at 10:10 AM, revealed the staff do the best they can; however, when they were busy, the resident takes himself/herself to the bathroom. The resident stated recently he/she had been treated for [REDACTED]. Sometimes he/she helped himself/herself to the bathroom when staff could not come at the time the call light was activated. The resident further stated he/she had had a couple of falls. The last fall required a stay in the hospital after hitting his/her head. Interview with the MDS Coordinator, on 04/24/15 at 3:45 PM, revealed the interventions for Resident #12 were not individualized specifically to the resident. 4. Observation, on 04/21/15 at 8:33 AM, during the facility tour, revealed Resident #29 was seated on the side of bed, and a wheelchair was located in the room. Resident #29 smiled and greeted this surveyor, stating he/she was hard of hearing while putting in a hearing device. Review of Resident #29's clinical record revealed the facility admitted the resident on 04/15/15 with [DIAGNOSES REDACTED]. Review of the facility's Lift/Mobility Assessment for Residents, dated 04/15/15, for Resident #29 revealed the facility assessed the resident and determined the resident required a stand up transfer with the use of a mechanical transfer device. Review of the Initial Care Plan for Resident #29 revealed the facility developed a Fall Care Plan on 04/16/15, due to the resident's history of falls at home, poor activity intolerance, weakness associated with Systolic [MEDICAL CONDITIONS] with an Ejection Fraction (EF) (EF of 20-25%), [MEDICAL CONDITIONS] ([MEDICAL CONDITION]), psychoactive medications, poor safety awareness, episodes of confusion, hard of hearing, a history of Spinal Fusion and left knee surgery. In addition, Resident #29 was at risk for bleeding or injuries with falls related to Aspirin therapy. Review of the CNA Care Plan utilized by CNA #9 and provided to the CNA by the facility, on 04/24/15, revealed Resident #29's care needs had not been updated for the CNA Care Plan since admission on 04/15/15. The CNA Care Plan included turn every two (2) hours as the only care need. Interview via telephone with RN #2, on 04/23/15 at 2:25 PM, revealed he was notified by the resident that he/she had fallen in the bathroom when he was making his morning rounds. He stated he was not notified in the shift report that Resident #12 had fallen. The alleged fall was not witnessed. He stated he completed an incident report because Resident #12 had reported the fall. He stated he had looked at the care plan and there was no need for a change; however, he did not assess the fall to make that determination. Interview with CNA #9, on 04/24/15 at 8:40 AM; and, at 10:04 AM, revealed she received her assignment information from the night shift supervisor upon her arrival. She stated she really just looked at the resident to see if she thought the resident could be transferred independently or if she needed the assistance of another person. She stated she was transferring Resident #29 by placing a wheelchair real close and holding onto the resident's pants to assist the resident to pivot and transfer with the resident was standing in front of the wheelchair. She stated Resident #29 was a tall person and it was difficult to transfer him/her because of his/her size. She stated her care plan for Resident #29 did not provide any care needs identified for Resident #29. She stated Resident #12 came to the facility with a Rolator walker. She stated she had spoken with the family and was told Resident #12 flops back on chairs when he/she sat down. She stated she told this information to the resident's nurse, LPN #3. Interview with East Unit Manager, on 04/24/15 at 9:15 AM and at 9:45 AM, revealed Resident #12 was admitted to the facility with a Rolator walker the resident used with ambulation. She stated the Resident's Daug
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, record review, and review of the [DEVICE] Assisted Closure (V.A.C.) Whitefoam Dressing Application Instructions, it was determined the facility failed to ensure the wound dressing was applied according to the manufacturer's recommendations and Physician Order. In addition, the facility failed to ensure Physician order [REDACTED].#1 and Resident #29). Licensed Practical Nurse (LPN) #1 placed the wound VAC foam on the intact skin of Resident

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F 0281 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) #1 during a dressing change. In addition, the nursing staff failed to obtain daily weights as prescribed by the physician and administer an additional dose of a diuretic to Resident #29, based on the physician's orders [REDACTED]. The findings include: 1. Interview with the Director of Nursing Services, on 04/23/15 at 3:10 PM, revealed the facility used the V.A.C. Whitefoam Dressing Application Instructions, dated December 2011, as the facility's policy for treatment of [REDACTED].A.C. therapy. Review of the Wound V.A.C. Whitefoam Dressing Application Instructions, dated December 2011, page nine (9) revealed do not allow foam to overlap onto intact skin. Protect fragile/friable periwound skin. Page fourteen (14), revealed the dressing foam must be cut to the dimensions that will allow the foam to be placed gently into the wound without overlapping onto intact skin. Care of the periwound skin included using a skin preparation product, such as a [MEDICATION NAME] or other transparent film, to protect the fragile skin around the wound from maceration. Review of the clinical record for Resident #1, revealed the facility admitted the resident on 08/22/14 with [DIAGNOSES REDACTED]. The resident developed gangrene in the right foot; the resident's right great and second toe were amputated. The resident was readmitted following the surgery on 04/14/15 with a [DIAGNOSES REDACTED]. The resident had a non-healing surgical wound which required treatment. Continued record review revealed the vacuum parameters were preset by the hospital. Review of the physician's orders [REDACTED].A.C. therapy for a surgical wound to the right foot and change every three (3) days or for increased drainage. Observation of Resident #1's wound treatment, on 04/22/15 at 2:22 PM, by the Treatment Nurse/LPN #1, revealed the V.A.C. was removed along with the soiled dressing. The nurse proceeded to apply the V.A.C. foam directly into the wound bed after trimming the foam with the intention to fit into the wound. The foam did not fit into the wound bed at the top where the toes were amputated and extended onto the intact skin up the right second toe. The foam dressing was sealed using the drape. This included sealing the foam over the intact skin. Interview with the Treatment Nurse, on 04/23/15 at 10:48 AM, revealed he was trained by the Distributor of the dressing, on the use of the Wound V.A.C. He stated he did not know what complications could result when the foam dressing was sealed and vacuum pressure applied to intact skin. Interview with the Director of Nursing Services, on 04/23/15 at 11:25 AM, revealed she had seen some problems with the Treatment Nurse's technique and had spoken to him about infection control and dressing changes; however, she did not have specific examples. She stated there was no facility policy on V.A.C. dressings and the instruction booklet would be the policy. She stated she had not read the instruction booklet regarding the V.A.C. 2. Review of the Weight Monitoring Policy, effective date 02/12/15, revealed to monitor nutrition and hydration the facility would obtain the height and weight of each resident. Weight would be recorded by the Nursing Department upon admission, monthly and more often if risk was identified. All weights would be reviewed by the Dietary Services Manager (DSM) and, the Registered Dietician (RD) would be notified of any significant weight changes or trends through the referral process. Review of Resident #29's clinical record, revealed Resident #29 was admitted on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #29's Admission Weight revealed a weight of 178.6 pounds. However, review of Resident #29's History and Physical and Discharge Orders from the hospital, dated 04/15/15, revealed Resident #29's weight was 232.5 pounds. Interview with the Unit Manager, on 05/05/15 at 3:00 PM, revealed she questioned the weight difference and obtained re-weights of 216, 213 and 212 pounds, but could not provide dates when these weights were obtained and she did not document these findings in the resident's clinical record. She thought the initial weights were wrong due to equipment failure. Review of Resident #29's follow up hospital clinic appointment; Physician Orders, dated 04/22/15, revealed Resident #29 was ordered daily weights at the same time in the morning (after he/she had emptied his/her bladder/voided). If the weight went up more than three (3) pounds in a day, give an additional dose of [MEDICATION NAME] ([MEDICATION NAME], a diuretic) forty (40) milligrams (mg) that day. Review of Resident #29's Medication Administration Record [REDACTED]. However, an as needed (PRN) order, to give [MEDICATION NAME] 40 mg by mouth for weight gain of over three (3) pounds was documented. Review of Resident #29's Vital Signs and Weight Flow Sheet revealed no evidence monthly weights were obtained after 04/22/15. Interview with Registered Nurse (RN) #2, on 05/05/15 at 1:30 PM, revealed when he placed orders into the computer, the order was to go under the MAR indicated [REDACTED]. RN #2 stated since the weights were not placed on the MAR, the weights were not obtained according to the physician's orders [REDACTED]. Interview with the Unit Manager, on 05/05/15 at 3:00 PM, revealed the RD was to obtain weights and place the weights into the computer. The Unit Manager stated she was not involved with the orders. Interview with the RD, 05/07/15 at 8:20 AM, revealed the DNS placed the weekly weights into the computer and sometimes the Unit Manager placed the monthly weights. The RD reviewed her notes on 04/24/15 about a recent diet change, but nothing about the daily weights. Interview with the DNS, on 05/05/15 at 3:00 PM, revealed the orders were documented wrong and were not placed into the computer correctly. The DNS was unaware of the weight or medication order.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, it was determined the facility failed to implement the care plan for one (1) of twenty-nine (29) sampled residents (Resident #29) regarding the monitoring and reporting of the ordered weights and blood pressures readings. The findings include: Review of the facility's policy titled, Weight Monitoring, dated 02/12/15 revealed, weight was recorded upon admission, monthly and more often if the resident was identified to be at risk. Review of Resident #29's clinical record revealed the facility admitted the resident on 04/15/15 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) Assessment, dated 04/28/15, revealed the facility assessed Resident #29 utilizing the Brief Interview of Mental Status (BIMS) with a score of fifteen (15) out of possible fifteen (15), meaning Resident #29 was cognitively intact and was interviewable. Review of Resident #29's Physician Orders, dated May 2015, revealed Resident #29 was ordered [MEDICATION NAME] (anti-hypertension medication) 50 milligrams (mg) by mouth twice daily, [MEDICATION NAME] (diuretic) 40 mg daily by mouth, and Aspirin 81 mg by mouth daily. The physician's orders [REDACTED]. Review of Resident #29's Initial Care Plan, dated 04/16/15, revealed Resident #29 was care planned to monitor his/her weights and report significant changes; to monitor (not defined by the facility) for signs and symptoms of fluid overload such as shortness of air, [MEDICAL CONDITION], hypertension and jugular vein distension; and, to observe for abnormal vital signs and report. Review of Resident #29's Vital Signs and Weight Flow Sheet revealed Resident #29's weight, on 04/15/15 was 178.6 pounds (lbs); on 04/16/15 his/her weight was 177.6 lbs; and, on 04/17/15 the resident's weight was 177.8 lbs. Further review revealed no evidence the resident's weights were obtained monthly after these dates. Review of Resident #29's Progress Notes, dated 04/15/15, revealed Resident #29's blood pressure was one hundred and thirty-nine over seventy-six (139/76). In addition, the Progress Notes, dated 04/18/15, revealed a blood pressure of ninety over fifty (90/50), without physician notification. (Review of the Progress Notes revealed no documentation of shortness of air or fluid overload.) Interview with the Director of Nursing Services, on 05/06/15 at 11:25 AM, revealed she was unable to discuss how the staff was following the care plan. She stated the care plan drove the care of the residents and she monitored delivery of care through multiple meetings and review of the 24 hour reports. She further stated the Unit Managers were not involved in the care plan process. However, they ensured staff followed the care plan by monitoring the 24 hour reports, labs, orders, admissions, family meetings and working with the pharmacy.

F 0309 **Level of harm -** Minimal harm or potential for 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**

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	185165	A. BUILDING _____ B. WING _____	06/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) Based on observation, interview, record review, and review of the [DEVICE] Assisted Closure (V.A.C.) Whitefoam Dressing Application Instructions, it was determined the facility failed to ensure the wound dressing was applied according to the manufacturer's recommendations and failed to ensure Physician order [REDACTED].#1 and Resident #29). Licensed Practical Nurse (LPN) #1 placed the wound VAC on the intact skin of Resident #1 during a dressing change and the nursing staff failed to obtain daily weights as prescribed by the physician in order to identify the need for an additional dose of diuretic, based on a three (3) pound weight gain, to Resident #29. The findings include: 1. Interview, on 04/23/15 at 3:10 PM, with the Director of Nursing Services, revealed the facility used the V.A.C. Whitefoam Dressing Application Instructions, dated December 2011, as the facility's policy for treatment of [REDACTED].A.C. therapy. Review of the Wound V.A.C. Whitefoam Dressing Application Instructions, dated December 2011, page nine (9) revealed do not allow foam to overlap onto intact skin. Page fourteen (14), revealed the dressing foam was to be cut to the dimensions that would allow the foam to be placed gently inside the wound without overlapping onto intact skin. Care of the periwound skin included using a skin preparation product, such as a [MEDICATION NAME] or other transparent film, to protect the fragile skin around the wound from maceration. Review of the clinical record for Resident #1, revealed the facility admitted the resident on 08/22/14 with [DIAGNOSES REDACTED]. The resident developed gangrene in the right foot and the right great and second toe were amputated. The resident was readmitted following the surgery on 04/14/15 with [DIAGNOSES REDACTED]. The resident had a non-healing surgical wound which required treatment. Review of the care plan, dated 03/19/15 for Resident #1, revealed the resident received an antibiotic daily for the wound infection and Wound V.A.C. therapy was used to treat the surgical wound. This wound treatment was scheduled to be completed every three (3) days. Observation, on 04/22/15 at 2:22 PM, of Resident #1's wound treatment, by LPN #1/Treatment Nurse, revealed the resident was in Contact Precautions related [MEDICAL CONDITION] in the wound. The nurse entered the room after donning a gown, a mask and gloves. The V.A.C. was removed along with the soiled dressing. The nurse washed his hands and applied clean gloves. The nurse proceeded to apply the V.A.C. foam directly into the wound bed after trimming the foam with the intention to fit into the wound. However, the foam did not fit into the wound bed at the top where the toes were amputated and extended onto the intact skin up the right second toe. The foam dressing was sealed using the drape and sealing the foam over the intact skin. Interview, on 04/23/15 at 10:48 AM, with the Treatment Nurse revealed he was trained by the Vendor of the dressing, on the use of the Wound V.A.C. He stated he did not know what complications could result when the foam dressing was sealed and vacuum pressure applied to intact skin. He stated he received continuing education updates from the Wound Care Institute. He stated the Director of Nursing Services observed the dressing change once a week and had mentioned his technique needed to improve; however, she did not provide further training. Interview, on 04/23/15 at 11:25 AM, with the Director of Nursing Services, revealed she observed wounds in the facility on a weekly basis. In addition, she was able to observe dressings being applied and removed on occasion, even though that was not the focus of the weekly wound review. She stated she had identified some problems with the Treatment Nurse's technique and had spoken to him about infection control and dressing changes; however, she did not have specific examples. She stated she did not have a written record of her audits or of any concerns regarding the Treatment Nurse's job performance. She stated there was no facility policy on V.A.C. dressings and the instruction booklet would be the policy. She stated she had not read the instruction booklet regarding the V.A.C. 2. Review of the Weight Monitoring Policy, effective date 02/12/15, revealed the staff was to monitor nutrition and hydration by obtaining the height and weight of each resident. Weight would be recorded by the Nursing Department upon admission, monthly and more often if a risk was identified. All weights would be reviewed by the Dietary Services Manager (DSM) and, the Registered Dietician (RD) would be notified of any significant weight changes or trends through the referral process. Review of Resident #29's clinical record, revealed the facility admitted the resident on 04/15/15, with [DIAGNOSES REDACTED]. Review of Resident #29's Admission revealed an admission weight of 178.6 pounds. Review of Resident #29's History and Physical and Discharge Orders from the hospital, dated 04/15/15, revealed Resident #29's weight was 232.5 pounds. Observation of Resident #29, on 05/06/15 at 9:45 AM, revealed Resident #29 was sitting in his/her wheelchair and the resident's bilateral lower extremities were slightly [MEDICAL CONDITION]. Interview, on 05/05/15 at 3:00 PM, with the Unit Manager, revealed she questioned the weight difference and obtained re-weights of 216, 213 and 212 pounds, but could not provide the dates when these weights were obtained. The Unit Manager stated she did not document these findings in the resident's clinical record. She thought the initial weights were wrong due to equipment failure. The Unit Manager stated she informed the Director of Nursing Services (DNS) and the RD. Review of Resident #29's, 04/22/15 follow up hospital clinic appointment; Physician Orders, revealed Resident #29 was ordered daily weights at the same time in the morning (after he/she had emptied his/her bladder/voided). If the weight went up more than three (3) pounds in a day, the staff was to give an additional dose of [MEDICATION NAME] ([MEDICATION NAME], a diuretic) forty (40) milligrams (mg) that day. Review of Resident #29's, May 2015 Medication Administration Record [REDACTED]. However, an as needed (PRN) order, to give [MEDICATION NAME] 40 mg by mouth for weight gain of over three (3) pounds was documented. Review of Resident #29's Vital Signs and Weight Flow Sheet revealed no evidence monthly weights were obtained after 04/22/15. Interview, on 05/05/15 at 1:30 PM, with Registered Nurse (RN) #2, revealed when he placed orders into the computer, the order was to go under the MAR indicated [REDACTED]. RN #2 further stated, the nursing staff who took the order off transcribed the order wrong and caused a medication error to occur. RN #2 stated since the weights were not placed on the MAR, the weights were not obtained according to the physician's orders [REDACTED]. Interview, on 05/05/15 at 3:00 PM, with the Unit Manager, on 05/05/15 at 3:00 PM, revealed the RD was to obtain weights and place the weights into the computer. The Unit Manager stated she was not involved with the orders. The Director of Nursing Services (DNS) was responsible to review orders in the AM (morning) Enhancement Meeting. The Unit Manager stated the nursing staff was responsible for checking the charts every twenty-four (24) hours to ensure orders were documented correctly. Review of Resident #29's Physician order [REDACTED]. However, the transcription error was not identified by the DNS during the Enhancement Meeting or the nurse who checked the chart for completion. Interview, on 05/07/15 at 8:20 AM, with the RD, revealed the DNS placed the weekly weights into the computer and sometimes the Unit Manager placed the monthly weights. The RD reviewed her notes on 04/24/15 about a recent diet change, but nothing about the daily weights. The RD further stated the physician orders [REDACTED]. Interview, on 05/05/15 at 3:00 PM, with the DNS, revealed the orders were documented wrong and were not placed into the computer correctly. The DNS was unaware of the weight or medication order. Further interview, on 05/06/15 at 8:40 AM, with the DNS, revealed the interdisciplinary team collaborated daily in the morning meetings by reviewing the history and physical, reviewing staff input, Nurses' Notes, 24 Hour Report Sheet; and, attending the AM Enhancement Meeting. Further interview with the DNS, revealed though the Unit Managers were not involved with resident care or the AM Enhancement Meetings, they were knowledgeable of the residents' [DIAGNOSES REDACTED].
F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents receive treatment/services to not only continue, but improve the ability to care for themselves.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure restorative services related to toileting and transfer assistance were provided for one (1) of fifteen (15) sampled residents. (Resident #8) The findings include:

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F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) Review of the facility's policy regarding Restorative Guidelines, not dated, revealed the facility provided a Restorative Nursing program with interventions that promoted the resident's ability to adapt and adjust to living as independently and safely as possible. Nursing restorative care included nursing interventions that assisted or promoted the resident's ability to attain his or her maximum functional potential. This did not include procedures or techniques carried out by, or under the direction of qualified therapists or exercise groups of more than four residents per supervising helper or caregiver. The following elements were in place for the facility to demonstrate satisfactory compliance with the guide: staff were trained in carrying out the Nursing Restorative Program; documentation of treatment matches frequency and content as per plan of care, and periodic evaluation of the resident's response to treatment. 1. Review of Resident #8's clinical record revealed the facility admitted the resident on 12/21/11 with [DIAGNOSES REDACTED]. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 07/17/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was unable to complete the interview. The MDS assessment stated the resident was currently on a toileting program and occasionally incontinent of urine and always continent of bowel. Review of the Comprehensive Care Plan for Resident #8 revealed a plan was developed on 05/02/11, with updated goals and a target date for 11/13/15. The problem stated the resident had an alteration in activities of daily living and required assistance with activities of daily living due to history of a stroke and right sided [MEDICAL CONDITIONS] and [MEDICAL CONDITION]. The goal stated the resident would be clean and dressed appropriately on a daily basis and would continue to feed self meals with set up through the next review. The approaches directed the facility to provide restorative services as ordered for transfer training-sit to stand at hand rail or hemi-walker three (3) times a day, scheduled toileting program as ordered and provide assistance with toileting. On 08/05/15 at 11:25 AM, an interview with Licensed Practical Nurse (LPN) #9, revealed Resident #8 needed the assistance of two (2) to toilet. She stated the resident was able to make his/her needs known to staff and would yell out, instead of using the call light for assistance when the resident needed to use the bathroom and staff would respond. She stated if staff was not within range they would not hear the resident yelling. Review of the POS [REDACTED]. The analysis stated the resident was found on the floor on his/her left side with the upper body in the adjoining resident's room. Recommendations made from the interdisciplinary team review were to immediately reassess the resident; reassess the resident's toileting program needs; refer the resident to therapy for screening or evaluation; for restorative to see as ordered; monitor for changes for three (3) days; and, report to the physician any change in the resident's condition. Review of the Restorative Bowel and Bladder Assessment, dated 08/05/15, revealed Resident #8 remained occasionally incontinent of bladder, continent of bowel and required assistance with transfers to the commode. Resident #8 was continent during the day, with several bladder incontinent episodes in the evening and during the night time hours. Resident #8 was currently on a toileting program during night time hours. The program was revised to include toileting times of before and after supper, at bedtime and every three (3) hours during the night. Review of Resident #8's Physician Orders, dated 08/05/15, revealed an order stated restorative nursing for transfer training-sit to stand at hand rail or hemi-walker times three every day shift. Review of the POS [REDACTED]. The document stated the resident had recently been evaluated by therapy and required extensive assistance with transfers. A toileting program was implemented on 08/05/15 related to functional incontinence; however, the resident attempted to transfer self to the toilet. A Restorative Program was ordered; however, the resident had only received twelve (12) of twenty-eight (28) sessions and from 07/27/15 to 08/07/15 the resident had only received two (2) fifteen (15) minute sessions. The recommended interventions were to perform an immediate assessment to report changes to the physician, provide assistance with transfers and provide a toileting program and restorative services as ordered. Interview with Assistant Director of Nursing (ADON), on 08/10/15 at 9:00 AM, revealed she had identified Resident #8 had not received the daily restorative care the resident was care planned for and thought maybe the resident had experienced a decline in ability so she ordered a therapy screen/evaluation, the resident's toileting program to be re-evaluated and for restorative to provide services daily. Continued interview with the ADON, revealed Resident #8 experienced another fall on 08/08/15 trying to transfer to the toilet again. She again completed the Post Analysis Fall Form and put the same interventions from the 07/27/15 fall as the recommendations. The ADON stated due to the CNA shortage and the facility using the RNAs as regular staff; the staff had not implemented the toileting and restorative care plan interventions as per their policy. She stated if the staff had provided toileting assistance to the resident the fall would have been prevented. Interview with the Restorative Nursing Assistant (RNA) #2, on 08/11/15 at 11:55 AM, revealed the restorative aides were pulled to work as a Certified Nursing Assistants (CNA). The facility was short CNAs on 08/08/15 and she was not able to complete the restorative program for Resident #8. RNA #2 stated there were three different assignment loads divided between (3) restorative aides for the residents in the building. The facility used the restorative aides to cover for the staffing shortage, due to CNA shortages which meant the restorative aides would not be able to provide the restorative services according to facility policy. Interview with Licensed Practical Nurse (LPN) #12, on 08/10/15 at 8:35 AM, revealed she was not sure what the toileting program requirements were for Resident #8 or if restorative was assisting the resident with toileting. Interview with the Restorative Nurse, on 08/05/15 at 1:32 PM, revealed she failed to perform a quarterly re-evaluation of Resident #8's response to restorative services. She stated she had been pulled frequently to work the floor as a staff nurse and was behind on her Restorative assessments. She stated she worked the weekend of 08/08/15 in a supervisory role and believed one of the restorative aides was also pulled to work the floor as a certified nursing aide; again preventing them from providing the required restorative services per policy requirements. She also stated she did not know Resident #8 had experienced another fall on 08/08/15. She stated staff normally just left her a note or verbally requested she perform an evaluation or re-evaluation of residents. She stated she had not received a request for Resident #8 to be reevaluated from the interdisciplinary team after the fall on 07/27/15 was unaware of the need for an assessment. She stated the resident should have received three (3) fifteen (15) minute restorative nursing sessions each day shift to work on transferring with a handrail. She stated from 07/17/15 through 08/05/15 the resident missed twelve (12) days of restorative services due to staffing. She stated a resident could experience a decline if they did not receive the amount of ordered restorative services they should. She stated Resident #8 had not received restoratives services as ordered and per the facility policy due to the restorative aides being pulled to work as floor aides. Interview with the Director of Nursing, on 08/12/15 at 5:20 PM, revealed she did not remember speaking about Resident #8's falls or care plan interventions related to toileting or the restorative programs during the morning meetings. She stated communication amongst the interdisciplinary team was an identified concern. She stated she had identified supervision of staff was an issue and she was working on a process to ensure the supervisory staff monitored for the implementation of restorative services. She stated the facility needed to ensure care plan interventions were implemented by the staff to prevent another fall for Resident #8 as per the care plan and facility policy. She further stated it was her responsibility to oversee the restorative programs; however, she was new to her role and was still working on other processes that needed to be addressed. Interview with the Administrator, on 08/12/15 at 5:50 PM, revealed she had identified the facility staff still needed additional education and supervision to ensure resident's restorative care plans were followed and the resident's needs were met. She stated the facility should have followed their restorative policies to ensure Resident #8 received the necessary toileting assistance and restorative services per his/her plan of care.
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 facility policy review, it was determined the facility failed to ensure

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F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) catheter tubing was secured to prevent extensive tension which could potentially cause tearing of the urethra and impede the flow of urine for one (1) of fifteen (15) sampled residents. (Resident #13) The findings include: Review of the facility's policy regarding Catheter (Indwelling), Insertion and Removal of (Female and Male), dated January 2015, revealed catheters should be secured to the leg with a catheter strap. Review of Resident #13's clinical record, revealed the facility admitted the resident on 03/26/15 with [DIAGNOSES REDACTED]. Review of the physician orders revealed an order, dated 03/27/15, for a Foley catheter to bed side drainage every shift for [MEDICAL CONDITION], flush as needed. In addition, Foley catheter care every shift and as needed every day shift for catheter placement. Review of Resident #13's Annual Minimum Data Set (MDS) assessment, completed on 06/11/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was not interviewable. The facility further assessed the resident with an indwelling catheter. Review of the Comprehensive Care Plan for Resident #13 revealed a plan was developed on 03/26/15, with updated goals and a target date for 10/24/15. The problem identified the resident as at risk for complications due to a Foley catheter in place related to a [MEDICAL CONDITION] Bladder with a history of [MEDICAL CONDITION]. The goal for the resident's catheter was to remain patent and functional through the next review. The interventions directed staff to assess the catheter for placement or tugging motion that could cause discomfort. Observation of Resident #13, on 08/12/15 at 9:03 AM, during catheter care revealed an unsecured Foley catheter tubing which was draped to the left side of the bed, with the catheter bag secured to the base of the bed. Interview with Registered Nurse (RN) #4, on 08/12/15 at 9:15 AM, revealed catheter tubing should be checked to ensure it was not occluded, the catheter bag should be below the level of the bladder, and should be secured to the bed. In addition, a Physician's order was needed for a catheter strap to secure catheter tubing to a resident's leg. She was unaware she was not following the facility policy that stated catheters should be secured to the leg with a catheter strap and no order was needed. Interview with the East Wing Nursing Supervisor, on 08/12/15 at 12:30 PM, revealed catheter tubing should be secured to a resident's leg with a catheter strap and no physician order was needed to obtain a catheter strap per facility policy. Interview with the Director of Nursing (DON), on 08/12/15 at 5:18 PM, revealed catheter tubing should be secured with a catheter strap to prevent pulling or injury. In addition, she stated the facility policy required staff to secure catheter tubing with a catheter strap and no Physician order was needed to obtain one. She further stated the staff were trained on the policy and the use of the catheter strap was basic nursing knowledge.
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** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to have an effective system in place to ensure the staff provided adequate supervision to prevent Sexual Acting Out (SAO) behaviors; and, failed to have an effective system to evaluate and identify interventions to prevent injurious falls for five (5) of twenty-nine (29) sampled residents (Resident #10, #1, #6, #11, and #12). In addition, the facility failed to ensure safe storage of hazardous materials in three (3) of four (4) shower rooms. The facility failed to provide supervision to the residents on the Alzheimer's Care Unit. On 03/11/15 at 5:50 AM, facility staff observed Resident #10 sitting on a couch next to Resident #18 sucking on his/her right breast. The facility placed Resident #10 on 1:1 supervision and requested inpatient psychiatric hospitalization . Review of the intake assessment conducted by the hospital, on 03/11/15 at 1:00 PM, revealed the resident was exhibiting sexually acting out (SAO) behaviors. The hospital Intake Coordinator documented the SAO behaviors presented a threat of harm to other residents. The facility identified the resident had a history of [REDACTED]. The resident required hospitalized from [DATE] to 03/24/15. Review of the facility's staffing for 03/11/15 revealed one nurse and one nurse aide was scheduled to care for thirty-one residents. Interview with Registered Nurse #6, on 04/23/15 at 1:45 PM, revealed there were two locked units, the Alzheimer's Care Unit (ACU) and the Advanced Alzheimer's Care Unit (AACU). She revealed she and the nurse aide was on the AACU together leaving the ACU with fifteen (15) residents unsupervised during the incident. The facility's failure to monitor Resident #10's SAO behaviors and provide adequate supervision resulted in an unsafe environment for other residents. The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents who exhibited SAO behaviors was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 03/11/15. The facility was notified of the Immediate Jeopardy on 04/24/15. An acceptable Allegation of Compliance was received on 04/29/15 which alleged removal of the Immediate Jeopardy on 04/29/15. An extended survey was conducted on 05/05/15 through 05/07/15. The State Survey Agency determined the Immediate Jeopardy was not removed on 04/29/15 as alleged, but on 05/07/15, prior to exit of the survey. The Scope and Severity was lowered to a G level (actual harm) for 42 CFR 483.25 (323) while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. In addition, the facility failed to have an effective system in place to identify the root cause of falls in order to identify interventions to prevent further accidents for residents. Resident #12 was identified by the facility as at risk for falls with a history of falling at home. Resident #12 sustained a fall on 03/26/15 transferring from the toilet unassisted. The resident sustained [REDACTED]. On 04/11/15, Resident #12 experienced slurred speech and was transferred to the hospital. The resident was admitted to the hospital with [REDACTED]. Resident #6 was identified as being at risk for falls and sustained falls on 01/18/15 with no injuries. On 02/22/15, the resident sustained [REDACTED]. Resident #6 was sent to the hospital and admitted to the hospital with [REDACTED]. Resident #11 was identified at risk for falls and sustained a fall on 03/14/15. The resident sustained [REDACTED]. Resident #1 sustained falls on 01/02/15, 01/27/15 and, on 03/14/15 and the facility failed to identify the root cause of the falls. In addition, observation of the shower rooms on the Alzheimer's Care Unit, Advanced Alzheimer's Care Unit and the East Wing-Hall C, revealed chemicals stored in unlocked cabinets. The units had cognitively impaired residents who wandered the units. On 05/05/15, observation of the East Wing Shower Room revealed a utility cart with a utility knife, a bottle of glue, a box that contained screws and other sharp metals. The findings include: Interview with the Director of Nursing Services (DNS), on 05/06/15 at 3:15 PM, revealed the facility did not have a policy on supervision of residents or falls prevention. Review of the facility's policy regarding Behavior Management Guideline, dated 02/12/15, revealed the facility was to develop behavior plans and medication regimens to optimize the functional abilities of residents while monitoring for adverse side effects and improved behaviors. The facility was supposed to utilize the Antecedent Behavior Monitoring Log for residents with behaviors that negatively affect functioning or quality of life. The Behavior Committee members were to review the log to identify patterns and causative triggering events for the behaviors and to measure the effectiveness of interventions. Additionally, the policy stated when the facility used an antipsychotic medication to treat an enduring condition; the facility must clearly and specifically identify and document the target behaviors. The facility must have clear documented evidence in the medical record that the situation or condition continued or recurred over time and the behaviors negatively affected the resident's quality of life. Interview with the Administrator, on 05/06/15 at 10:53 AM, revealed the facility did not utilize the Antecedent Behavior Monitoring Log before the Immediate Jeopardy. He stated it was available in the Corporate policies on-line and he was to utilize the form; however, neither he or the DNS had implemented the form. Therefore, the Behavior Committee did not review residents' behaviors at the weekly meetings according to the Corporate policy. He stated he could not recall when the Behavior Management Guidelines went into effect and could not recall if he received an e-mail regarding the new policy as was the practice of the Corporation.

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	185165	A. BUILDING _____ B. WING _____	06/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - CAMELOT	1101 LYNDON LANE LOUISVILLE, KY 40222

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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 10) Review of the Corporate guidelines for Communication and Documentation of an Event, dated 02/10/10, defined an event as an incident that resulted in, or had the potential to result in, physical or mental harm to a resident. Per the guidelines, an event included resident-to-resident altercations and demonstrated high-risk patient behaviors or situations. When an event occurred, the facility was always to complete a thorough and objective Verification of Investigation form. 1. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 04/08/12 with [DIAGNOSES REDACTED]. Review of the most recent physician's orders [REDACTED]. Review of Resident #10's Quarterly Minimum Data Set (MDS) assessment, completed on 12/23/14, revealed the facility completed a Brief Interview Mental Status (BIMS) examination with a score of eleven (11) out of fifteen (15), indicating the resident had moderate cognitive impairment. The MDS assessed the resident as not exhibiting any physical, verbal, or other behaviors directed at himself/herself or others during the seven (7) day look back period prior to completion of the MDS assessment. Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 04/13/15, revealed the facility assessed the resident requiring only supervision or limited assistance to complete Activities of Daily Living (ADL). The resident was able to transfer and walk in the corridor with supervision only. The facility did not assess the resident's BIMS for this MDS assessment. The MDS assessed the resident as not exhibiting any physical, verbal, or other behaviors directed at himself/herself or others during the seven (7) day look back period prior to completion of the MDS assessment. Review of the care plan for Resident #10, initiated on 08/13/14 with a print date of 01/27/15 and reviewed on 03/24/15, revealed the resident had sudden sexual impulses and touched staff in inappropriate manners. The interventions specifically specified the resident would redirect himself/herself when he/she felt an impulse coming on, and the facility would monitor the resident for increased emotional distress. The facility dated these interventions 08/13/14. On 03/24/15, the facility updated the resident's care plan pertaining to behaviors of shouting and rejecting care to assess for inappropriate sexual behaviors and aggression and report to MD. Review of the Progress Notes, dated 06/06/14 at 11:29 AM, revealed the ACU Manager documented the Psychiatrist had met with Resident #10 on 06/06/14 and discussed the resident's behaviors with the ACU Manager. The Note stated the resident had sexual behaviors toward staff including touching female staff in inappropriate places. The ACU Manager documented an unsuccessful intervention stating staff had not been able to redirect Resident #10. Review of the Psychiatric Consult/Follow-Up for Resident #10, dated 06/06/14, revealed the facility consulted with the Psychiatrist due to increased SAO behaviors. The document reported Resident #10 had touched females on the buttocks. The Psychiatrist increased the medication Premarin (to help decrease sexual urges) from 0.625 mg (milligrams) to 1.25 mg at the time of the consult. Review of the Interdisciplinary Progress Notes, dated 08/12/14 at 8:45 AM, revealed staff observed Resident #10 hugging a female resident. The Note indicated staff was able to redirect the resident and placed the resident on fifteen (15) minute checks. Further review of the Progress Notes revealed the fifteen (15) minute checks continued through 08/14/14. Review of the Psychiatric Consult/Follow-Up, dated 08/12/14, revealed the facility consulted with the Psychiatrist. Under reason for visit, the document stated the resident continued to inappropriately touch females' (staff and peers) buttocks and breasts. The Consult further stated the behaviors were impulsive and the resident was unable to remember any of these behaviors. Review of the Progress Notes, dated 08/16/14 at 2:10 PM, revealed nursing documented Resident #10 touched a nurse on the buttocks and staff redirected the resident. The Note did not include effectiveness of the intervention. On 08/16/14 at 10:14 PM, a different nurse documented Resident #10 had no behaviors; however, documented the resident was on fifteen (15) minute checks due to a history of touching others. The Progress Notes contained no other reference to the fifteen (15) minute checks or additional supervision required post incident. Interview with the ACU Manager, on 4/24/15 at 10:30 AM, revealed the facility monitored residents when they had SAO behaviors by placing the resident on the 24-hour report and placing the resident on fifteen (15) minute checks, usually for three (3) days. After Resident #10 returned from the hospital, the facility did not change or increase supervision on the unit. Review of the Progress Notes, dated 12/20/14 at 1:18 AM, revealed the facility documented they had placed Resident #10 on fifteen (15) minute checks due to sexual behaviors. The Progress Notes did not indicate what SAO behaviors the resident exhibited to warrant placing him/her on fifteen (15) minute checks. In addition, the Progress Notes did not indicate what interventions the facility used when the SAO behaviors occurred or what interventions the facility would use to prevent reoccurrence of the behavior. Continued review of the clinical record revealed the next documented instance of SAO behaviors occurred in a Progress Note written on 01/12/15 at 2:15 PM. At that time, nursing documented Resident #10 had touched a Certified Nursing Assistant (CNA) on the buttocks earlier in the morning. The nurse also documented she would continue to monitor for behaviors. The Note did not indicate what intervention nursing used or what monitoring the facility implemented. The facility did not document in the clinical record that any increased supervision was provided following that incident. Review of the Progress Notes, dated 01/30/15 at 2:40 PM, revealed nursing staff documented they had placed Resident #10 on fifteen (15) minute checks due to increased behaviors and needing redirection from female residents. The record did not indicate what behavior the resident exhibited or if any interventions were used with the resident. In addition, the record did not indicate how long the resident would remain on fifteen (15) minute supervision. The facility did not document any additional Progress Notes pertaining to the resident's behaviors or fifteen (15) minute supervision in the shifts that followed. Review of the Psychiatric Consult/Follow-Up, dated 02/06/15, revealed the facility consulted with the Psychiatrist due to Resident #10 becoming more inappropriate with touching other residents and staff. The Consult further revealed the resident had Dementia and Sexual Acting Out (SAO) behaviors and the facility had previously attempted a Gradual Dose Reduction (GDR) of Risperdal. Review of the Progress Notes for Resident #10, on 03/11/15 at 5:50 AM, revealed nursing staff made an entry in the Progress Notes under Behavior Charting. Staff noted Resident #10 was sitting in the common area sucking on the breast of Resident #18. The resident refused to leave the common area after the incident. Staff documented vital signs and reported the resident was calm within twenty (20) minutes of the incident. However, the Note does not include what staff did to ensure the safety of other residents. A Progress Note, dated 03/11/15 at 9:26 AM, revealed nursing notified the physician of the incident. At 10:20 AM, the nurse notified the Psychiatrist of Resident #10's behaviors. The Note further revealed the Psychiatrist ordered to send the resident out for further psychiatric evaluation. Review of the Verification of Investigation form for Resident #10, dated 03/11/15 at 5:50 AM, revealed staff observed Resident #10 sitting in the common area sucking on the breast of Resident #18, who was sitting next to him/her. The form stated the residents were immediately separated for their protection and staff placed Resident #10 on one-on-one (1:1) supervision until the resident left the facility to go to the hospital. The facility staff did not complete the portions of the Verification of Investigation form labeled Summary and Outcome of Investigative Findings. Review of the Verification of Investigation form for Resident #18, dated 03/11/15 at 5:50 AM, revealed staff observed Resident #18 sitting on the couch raising his/her pajama top. Resident #10 was sitting on the couch next to Resident #18 and was sucking on Resident #18's breast. Resident #18 had come out of his/her room and into the common area between 5:43 AM and 5:50 AM. At the time of the incident, staff separated the residents immediately and a completed an assessment. Staff placed Resident #18 on fifteen (15) minute checks. The facility staff did not complete the portions of the Verification of Investigation form labeled Summary and Outcome of Investigative Findings. Review of the MDS for Resident #18, on 03/17/15, revealed the facility assessed the resident to have a BIMS score of 9, indicating moderate cognitive impairment and non-interviewable. Review of the Integrated Level of Care Intake Assessment from the Psychiatric Hospital, dated 03/11/15, revealed the hospital staff documented the facility staff had reported Resident #10 was in the common area sucking on another resident's breast; and, had been touching staff and peers on the genitals and bottom. The evaluation further stated staff had found Resident #10 between multiple residents' legs in their bedrooms and had a resident bent over and was humping the resident from behind. Under the section for high risk factors, the assessment indicated Resident #10 was at risk of sexual perpetration due to SAO behaviors. The indicators included the resident touching and fondling females, putting resident's breast in his/her mouth, exposing himself/herself to others, and bending a resident over and humping the resident from behind. The section for The assessment for sexually acting out risk factors, stated the resident had pulled his/her and

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) others' pants down; humped another resident; and, had touched other residents and staff on the breasts, genitals, and bottom. The intake assessment also documented Resident #10 was not oriented and did not remember acting out sexually. Interview with CNA #5, on 04/22/15 at 2:15 PM, revealed Resident #10 had a history of [REDACTED].#10. She also stated the resident had not experienced these behaviors since the last medication adjustment on 02/06/15. Interview with the ACU Manager, on 04/23/15 at 11:00 AM, revealed Resident #10 had a history of [REDACTED].#10 had a history of [REDACTED]. She stated the Psychiatrist was at the facility each Tuesday and Friday to discuss patients on the ACU and AACU. On 01/30/15, the ACU Manager documented she had placed Resident #10 on fifteen (15) minute checks due to increased SAO behaviors. The Unit Manager stated she failed to document what specific behaviors the resident was displaying at the time or for how long the resident was to stay on fifteen (15) minute checks. She stated she remembered she placed Resident #10 on the fifteen (15) minute checks after she found a resident of the opposite sex in Resident #10's room with him/her. The Unit Manager stated she did not observe any inappropriate touching on that occasion. Further interview with the ACU Manager on 04/23/15 at 11:00 AM, revealed in order to increase monitoring of the resident, the nursing staff would put Resident #10 on fifteen (15) minute checks anytime he/she had SAO behaviors. The Unit Manager also stated the Dose Reduction Committee, consisting of the Psychiatrist, the Unit Director, the DNS, and the Unit Nurse, decided on 02/26/15 to do a gradual dose reduction of psychiatric medications for Resident #10 to reduce sleepiness during the day. At the time of the GDR, initiated on 02/26/15, Resident #10 was not exhibiting SAO behaviors. The Unit Manager stated after initiating the GDR, Resident #10 had not had any increased behaviors. Continued interview with the ACU Manager, on 04/23/15 at 11:00 AM, revealed Resident #10 and Resident #18 became focused on each other. She stated Resident #18 also had SAO behaviors and had been flirtatious with Resident #10. The ACU Manager stated the staff redirected both of the residents many times; however, because of cognitive problems; the residents would quickly forget the redirection and start to focus on each other again. The ACU Manager stated nursing did not document these redirections in the Progress Notes. Additionally, the ACU Manager stated on 03/11/15 staff observed Resident #10 with his/her mouth on the breast of Resident #18. The Unit Manager stated the facility sent Resident #10 to the hospital on [DATE] due to increased SAO. The ACU Manager stated Resident #18 also had SAO and believed the incident was consensual between the two (2) residents. However, after consultation with the Psychiatrist and because the residents were not easily redirected and Resident #10 had a history of [REDACTED].#10 to the hospital for evaluation and medication adjustments. The ACU Manager revealed Resident #10 had multiple GDR attempts in the past that resulted in SAO behaviors. Interview with Registered Nurse (RN) #6, on 04/23/15 at 1:45 PM, revealed she was the nurse on duty the morning of 03/11/15. RN #6 stated she was working on the AACU side passing medications and the CNA was on the AACU side providing care to another resident. The RN stated when she returned to the nurses' station she observed Resident #10 with his/her mouth on the breast of Resident #18. The RN reported she escorted Resident #18 back to his/her room and returned to Resident #10. RN #6 asked Resident #10 to return to his/her room and he/she declined three (3) times. The resident did not talk or answer any questions the RN asked. The RN then called the supervisor and reported the incident. The Supervisor requested the RN write a statement and put Resident #10 on one-on-one supervision. At the time of the incident, no staff was present to supervise the residents on the ACU side. The RN stated on the night shift the facility only had one nurse and one CNA for the ACU and AACU units. RN #6 stated Resident #10 had a history of [REDACTED]. Review of the Daily Census, dated 03/11/15, revealed the ACU and AACU had thirty-one (31) residents on the units combined. Interview with the Administrator, on 04/22/15 at 4:00 PM, revealed an investigation of the event was started on the day of the incident (3/11/15) but stopped because after a discussion with the DNS, they did not consider it to be a reportable (sexual abuse) instead just behaviors. He stated Resident #10 was placed on 1:1 supervision until he/she was transferred to the hospital. He stated he had not reviewed the staffing for supervision and was not aware the residents had been left alone, unsupervised. He stated he had not been told of any problems with supervision. Since no investigation was completed, the incident was not discussed in a Quality Assurance (QA) meeting. Further interview with the Administrator, on 04/23/15 at 2:15 PM, revealed the Administrator did not report the incident because he did not believe that it was an abuse situation, but rather impulsive sexually acting out behaviors. The Administrator stated he knew Resident #10 was on psychiatric medications for behaviors, but he did not know for what specific behaviors. The Administrator also stated both residents were participating and he believed the act was consensual. The Administrator discussed the incident in the morning meeting with the DNS. They determined the situation was not reportable. At that point, the Administrator stopped investigating the incident. Interview with the ACU Manager, on 4/24/15 at 10:30 AM, revealed the facility was aware Resident #10 had inappropriate sexually acting out behaviors prior to 03/11/15. The ACU Manager stated Resident #10 would try to touch others inappropriately and would try to walk other residents into his/her room. Resident #10 had touched staff on the buttocks. She stated she had reported staff had observed Resident #10 in another resident's room standing over the other resident. The ACU Manager also stated Resident #10 touched staff a lot, and then started with Resident #18. Interview with the ACU Social Worker, on 04/24/15 at 10:30 AM, revealed she had not read the psychiatric hospital assessment completed on Resident #10. After reviewing the psychiatric hospital's assessment, the Social Worker stated she was unaware of Resident #10 exposing himself/herself to others. Interview with the DNS, on 04/24/15 at 10:30 AM, revealed she had not read the psychiatric hospital assessment completed on Resident #10. After reviewing the psychiatric hospital's assessment, the DNS stated she was unaware of the behaviors reported under the section titled Current Presenting Problems. The DNS further stated the night nursing staff print out any documentation typed into the computer and placed it in the charts each night. The DNS stated she and the Administrator discussed the behaviors of both Resident #10 and Resident #18 to make the determination that the incident on 03/11/15 was not a reportable abuse situation; therefore, did not conduct an investigation. The DNS stated she did not have the hospital's intake assessment at the time she and the Administrator determined it was just behaviors. The hospital sent the assessment when they discharged Resident #10 back to the facility on [DATE]. The DNS further stated the facility had not added staffing on the night shift after the incident on 03/11/15. She stated the facility continued to staff the ACU and AACU with one (1) nurse and one (1) CNA for both units. However, she had not interviewed the nurse and CNA that had worked the morning of the incident and did not know the residents had been left unsupervised. Interview with the Intake Evaluation Coordinator #2 from the hospital, on 04/24/15 at 11:15 AM, revealed she completed an evaluation for Resident #10 on 03/11/15 at the facility. The Intake Coordinator stated she gathered information for evaluations from the nursing home staff and the resident's chart. She also stated she gathers information from family members when possible. She stated if she had talked with Resident #10's family, she would have indicated that in the evaluation on page four (4). On the evaluation, the information placed under The Immediate Problem section of the document stated the reason the facility called the hospital for the evaluation, the presenting problem. The precipitant to that problem was any behaviors or issues that lead to the episode. The Intake Evaluation Coordinator revealed she had a lengthy conversation with the nurse at the facility. The nurse told the Evaluation Coordinator about the incident that happened that day. The Intake Evaluation Coordinator also revealed she looked through the entire chart to make her evaluation. From interview and record review, the Evaluation Coordinator documented Resident #10's current medications, conditions, and behaviors including sexually acting out (SAO) behaviors. Interview with Resident #10's Psychiatrist, on 04/24/15 at 2:05 PM, revealed Resident #10 had a [DIAGNOSES REDACTED]. Because of this, staff must redirect the resident many times. The Psychiatrist stated that due to the resident's size and history of SAO, the Psychiatrist placed Resident #10 on Premarin to help decrease sexual urges. Resident #10 would have periods of doing well and would then impulsively exhibit SAO behaviors. The Psychiatrist was aware of the incident on 03/11/15 and stated he thought it was impulsive behaviors instead of a perpetrator instinct because the resident was unable to plot or plan as a perpetrator. Unlike a perpetrator, the resident did not try to hide his/her actions or isolate a victim. Instead, Resident #10 acted in front of staff. Additionally, Resident #10 required redirection often because he/she could not remember. The facility sent the resident for inpatient treatment because the interventions in place were not working or because the environment was not safe due to his/her behaviors. The Psychiatrist further stated that a BIMS score of eleven (11) for Resident #10 was not a good indicator of cognition because a resident could have a reserve of knowledge and score well one day and not well on another day. However, functionally, the resident could not care for self and did not have the cognition to solve problems. Interview with the Administrator, on 05/05/15 at 8:40 AM, revealed the facility had a morning meeting, Monday through

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 12) Friday, to discuss various issues including resident behaviors. On the weekends, the Charge Nurse conducted meetings with the supervisors. The Administrator stated the facility started using behavior logs to document resident behaviors. When a behavior happened, the Unit Manager would document that behavior in the progress notes or SBAR (Situation, Background, Assessment, and Recommendation). The SBAR triggered the incident report. The Social Worker would bring the behavior logs to the morning meetings any time after a behavior occurred. The Social Worker and the DNS audited the behavior logs and behavior monitoring. The facility held weekly Behavior Meetings to review behaviors in order to track the behaviors and prevent reoccurrence. Interview with CNA #13, on 05/05/15 at 3:55 PM, revealed the CNA was unable to see both the ACU and the AACU residents when working on one of the two units. The CNA stated she worked third (3rd) shift on the ACU and AACU. The facility staffed the two units with one (1) nurse and one (1) CNA. CNA #13 stated it was not policy to ensure that if the nurse is working on one hallway, that the CNA would be on the other hallway. The CNA stated the ACU and AACU contained residents who wander and who would get up early in the morning. Often a resident would wander into other resident's rooms. If a situation existed that required staff to provide one-on-one monitoring or other resident issues, such as working with a resident who had fallen or who was exhibiting behaviors, then the CNA would not have been able to monitor the rest of the unit. Additionally, CNA #13 revealed she could not supervise both the ACU and the AACU at the same time. The CNA stated it was impossible to view one hallway when on another. The CNA stated she tried to ensure she was on the opposite hallway when the nurse was working on one of the hallways, but that was not a facility policy. Interview with CNA #14, on 05/05/15 at 4:14 PM, revealed the CNA was not able to supervise both the ACU and the AACU at the same time with one nurse and one CNA working the unit at night. The CNA stated she could not visually see both units unless she was in the office, and then was not able to see the back portion of the ACU. The CNA stated residents would frequently get up in the night and many would wander into other resident's rooms. She stated that at times both the CNA and the nurse were required to work on the same hallway at the same time. When the CNA and the nurse worked on the same hallway at the same time, nobody was monitoring the other hallway. A telephone interview with CNA #12, on 05/05/15 at 9:40 PM, revealed third shift, when staffed with one (1) nurse and one (1) CNA, could not have adequately supervised the ACU and AACU. The CNA stated she was unable to see both units at the same time. CNA #12 revealed that from the nurses' station one could see down the AACU and could see about half of the rooms on the ACU hall. From the nurses' station, one would not be able to view down the back half of the ACU. The CNA stated many of the residents on the backside of the ACU wandered. Those residents wandered into each other's rooms frequently, including at night. CNA #12 revealed there were times when the nurse and the CNA would have to work on the same hallway, leaving the other hallway unsupervised. She stated when this happened there was no way to know what was happening on the other unit. Further, CNA #12 stated many of the residents on the unit had behaviors, including SAO's and fighting. Many residents were often up at all hours of the night. Further interview revealed CNA #12 discussed the morning of 3/11/15. The CNA stated she was working on the AACU giving care to a resident. The nurse was about to give nursing care to another resident on the AACU. After a few moments, the nurse went back to the nurses' station for a needed item pertaining to the care she was giving. When she entered th
F 0353 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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** Based on interviews and review of facility staffing, it was determined the facility failed to have an effective system to ensure adequate staffing for supervision of residents with behaviors for two (2) of seven (7) residential units. This failure affected two (2) of twenty-nine (29) sampled residents, Residents #10 and #18. (Refer to F323) Record review and interview revealed on 03/11/15 at 5:50 AM, the facility staff observed Resident #10 sitting on a couch next to Resident #18 sucking on his/her right breast. The clinical record identified the resident to have a history of fondling, touching other residents, and exposing self to others. Review of the facility's staffing for 03/11/15 revealed one nurse and one nurse aide was scheduled to care for thirty-one residents. Interview with Registered Nurse #6, on 04/23/15 at 1:45 PM, revealed there were two locked units, Alzheimer's Care Unit (ACU) and Advanced Alzheimer's Care Unit (AACU) with the Nurses' Station between the units. She revealed she and Certified Nursing Assistant (CNA) #12 was on the AACU at the time of the incident and left fifteen (15) residents on the ACU unsupervised. The facility's failure to monitor Resident #10's behaviors and provide adequate supervision resulted in an unsafe environment for other residents. The facility's failure to have an effective system in place to ensure sufficient staffing was available to monitor behaviors has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was determined to exist on 03/11/15. An Acceptable Allegation of Compliance (AOC) was received on 05/28/15 which alleged removal of the Immediate Jeopardy on 05/28/15. The State Survey Agency determined the Immediate Jeopardy was removed on 05/28/15 prior to exit of the survey on 06/03/15. The scope and severity was lowered to a D while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Interview with the Director of Nursing Services (DNS), on 04/24/15 at 10:30 AM, revealed the facility did not have a specific policy for staffing. She stated the Alzheimer Care Units (ACU) were staffed with one nurse and one nurse aide at nights. She stated that had been sufficient staffing before and she thought it was adequate. She stated the House Supervisor could help if needed. She stated Residents' #10 and #18 exhibited behaviors and required redirection. Review of the progresss notes for Resident #10, revealed on 03/11/15 at 5:50 AM, the facility staff observed Resident #10 sitting on a couch next to Resident #18 sucking on his/her right breast. The facility placed Resident #10 on 1:1 supervision and requested inpatient psychiatric hospitalization . Review of the intake assessment conducted by the hospital, on 03/11/15 at 1:00 PM, revealed the resident was exhibiting sexually acting out (SAO) behaviors. The hospital Intake Coordinator documented the sexually acting out behaviors presented a threat of harm to other residents. The facility identified the resident had a history of [REDACTED]. Review of the daily census, dated 03/11/15, revealed the Alzheimer's Care Unit (ACU) and the Advanced Alzheimer's Care Unit (AACU) had thirty-one (31) residents on the units combined. Review of the facility's staffing for the night shift (11 PM-7:00 PM) on 03/11/15, revealed one nurse and one nurse aide was scheduled to care for the thirty-one residents. Interview with Registered Nurse (RN) #6, on 04/23/15 at 1:45 PM, revealed there were two locked units: Alzheimer's Care Unit (ACU) and Advanced Alzheimer's Care Unit (AACU). She revealed she was the nurse on duty at the incident of 03/11/15. RN #6 stated she was working on the AACU passing medications and the Certified Nursing Assistant (CNA) was also on the AACU providing care to another resident. The RN stated when she returned to the nurses' station she observed Resident #10 with his/her mouth on the breast of Resident #18. At the time of the incident, no staff was present to supervise the ACU side. The RN revealed on the night shift the facility only had one nurse and one CNA for the ACU and AACU. RN #6 stated Resident #10 had a history of [REDACTED]. Interview with CNA #13, on 05/05/15 at 3:55 PM, revealed the CNA was unable to see both the ACU and the AACU when working on one of the two units. She worked third (3rd) shift for both units and revealed the facility staffed the two units with one (1) nurse and one (1) CNA. CNA #13 stated it was not policy to ensure that if the nurse was working on one hallway, the CNA would be on the other hallway. The CNA stated the ACU and AACU contained residents who wandered and who would get up early in the morning. Often a resident would wander into other residents' rooms. If a situation existed that required staff to provide one-on-one monitoring or other resident issues, such as working with a resident who had fallen or who was exhibiting behaviors, then the CNA would not have been able to monitor the rest of the unit. Additionally, CNA #13 revealed she could not supervise both the ACU and the AACU at the same time. The CNA stated it was impossible to view both units at the same time. The CNA stated she tried to ensure she was on the opposite unit then the nurse, but that was not a facility policy. Interview with CNA #14, on 05/05/15 at 4:14 PM, revealed the CNA was not able to supervise both the ACU and the AACU at the same time with one nurse and one CNA working the units at night. The CNA stated she could not visually see both units

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F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) unless she was in the nurses' station, and then she could only see the front half of the ACU. The CNA stated residents would frequently get up in the night and several residents would wander into other residents' rooms. She stated at times both the CNA and the nurse were required to work on the same unit at the same time, leaving the other unit unsupervised. A telephone interview with CNA #12, on 05/05/15 at 9:40 PM, revealed when third shift was staffed with only one (1) nurse and one (1) CNA, she could not adequately supervised the ACU and AACU. The CNA stated she was unable to see both units at the same time. CNA #12 stated that from the nurses' station one could see down the AACU and could see about half of the rooms on the ACU hall. From the nurses' station, one would not be able to view down the back half of the ACU. The CNA stated many of the residents on the backside of the ACU wandered. Those residents wandered into each other's rooms frequently, including at night. CNA #12 stated there were times when the nurse and the CNA would have to work on the same unit, leaving the other unit unsupervised. She stated when this happened there was no way to know what was happening on the other unit. Further, CNA #12 stated many of the residents on the unit had behaviors, including SAO's and fighting. Many residents were often up at all hours of the night. Review of facility staffing from March 1 through March 11, 2015 revealed one nurse and one nurse aide scheduled for the night shift in the ACU and AACU Units to care for 30-32 residents. Interview with Registered Nurse #6, on 04/23/15 at 1:45 PM, revealed there were two locked units, the Alzheimer's Care Unit (ACU) and the Advanced Alzheimer's Care Unit (AACU). She stated she and the nurse aide were on the AACU together leaving the ACU with fifteen (15) residents unsupervised during the incident. Continued review of the facility's staffing schedule for March 12 through 04/27/15 revealed it continue to schedule one nurse and one nurse aide to the AACU and ACU for the night shift for 30-32 residents. Interview with the Staffing Coordinator, on 05/06/15 at 8:41 AM, revealed she was told to staff the locked units with one nurse and one aide for the night shift. She stated she had scheduled two nurse aides for the night shift (11 PM-7 AM) in the ACU Units since 04/28/15. She stated the only day there was not two aides for the night shift was on Saturday, 05/03/15. She stated the night shift was the only shift to have additional staff added. She stated the facility did not use agency staff. She stated she had PRN (as needed) staff to pull from when there was a call in and other staff would pick up an extra shift. The facility took the following actions to remove the Immediate Jeopardy on 05/28/15 by implementing the following: 1. Resident #10 was separated from the female residents and placed in sight of staff until transferred to a behavior unit for treatment on 03/11/15. Resident #10's documentation was noted in the Caretracker and Point Click Care by the Unit Manager on 04/26/15. On 03/11/15 the Charge Nurse and Certified Nursing Assistant took immediate action to ensure the safety of other residents by closely monitoring Resident #10 until transfer to the behavior treatment unit at approximately 5:20 PM. No other behaviors occurred. 2. On 04/28/15, The Nursing Home Administrator and Director of Nursing Services discussed staffing patterns in the Alzheimer's Care Unit (ACU) and Advanced Alzheimer's Care Unit (AACU) on the 11-7 shift. It was determined one Certified Nursing Assistant was added to the 11 PM-7 AM shift on the Alzheimer's Care Unit. 3. On 04/25/15 and 04/26/15 conference calls were conducted with the Administrator and Director of Nursing Services. The facility's Health Care Council guided the Administrator and the Director of Nursing Services through the location on the Policy Center and existence of behavior monitoring guidelines and log. The Area Vice-President and Field Services Clinical Director were present for both calls. On 04/27/15 the Field Services Clinical Director provided additional education to the Administrator, Director of Nursing Services, Assistant Director of Nursing, ACU/AACU Director, Director of Clinical Education, and Social Services Director on behavior management guidelines and monitoring. The Director of Nursing Services and Assistant Director of Nursing Services received education on the Behavioral Management Guideline Policy, on 03/26/15, during the quarterly clinical guideline training hosted by the Field Services Clinical Director. On 04/25/15, the Administrator received education related to the Behavior Guideline and Monitoring by the Health Care Council. The Administrator ensured the Director of Nursing Services began education and no employee would work unless they received the education. The Administrator monitored progress at least daily in the Clinical Start-Up meeting at least daily. On 04/27/15, the Files Services Clinical Director provided additional education to the Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education, ACU/AACU Director, and Social Services Director on behavioral management guidelines and behavior monitoring and charting. On 04/27/15, the Administrator consulted with the Field Services Clinical Director for investigations and incidents that may result as a reportable. There were two (2) incidents reported in April and eight (8) incidents reported in May. 4. An Ad Hoc Quality Assurance Process Improvement meeting, consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Director of Education and the Medical Director by phone was held on 04/27/15 to discuss the event of 03/11/15 and to develop a plan to prevent reoccurrence. The behavioral management guidelines and monitoring plan that the facility had implemented was discussed with the Medical Director via phone. A Quality Assurance Process Improvement Committee meeting will be held weekly x 4 weeks, then monthly thereafter. The committee will review results of the care plan and behavior log audits, behavior monitoring, and any investigations or [MEDICATION NAME]. The Behavior Monitoring Log is utilized for residents who are exhibiting behaviors. The audit identifies patterns and positive or triggering events and effectiveness of interventions. The audits will be completed weekly by the Social Worker and Director of Nursing Services and/or Assistant Director of Nursing Services. The Administrator held Quality Assurance Process Improvement meetings to review behavior care plan logs, audits, [MEDICATION NAME], and investigations on 05/04/15, 05/14/15, 05/21/15. The State Survey Agency validated the removal of Immediate Jeopardy on 06/03/15 prior to exit as follows: 1. Interview with Licensed Practical Nurse #13, on 06/01/15 at 2:55 PM, revealed until Resident #10 was transferred to a local behavioral unit he/she was kept in staff view. Review of Caretracker and Point Click Care revealed the resident was placed on 1:1 supervision until transferred on 03/11/15. Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed Resident #10 was placed on observations for the safety of ACU/AACU residents. Review of the Discharge Summary from the behavior unit on 06/02/15 revealed, Resident #10 was admitted for evaluation on 03/11/15 and discharged on [DATE] back to the facility. Interview with Licensed Practical Nurse #7, on 06/02/15 at 6:25 AM, revealed on the morning of 03/11/15 she separated the residents without difficulty and reported the incident to the House Supervisor. She stayed with the female resident and the male resident was taken to his room. Resident #10 was then monitored. 2. Interview with the Director of Nursing on 06/03/15 at 8:30 AM, revealed the staffing schedule was revised to include two (2) Certified Nursing Assistants were now scheduled on the 11:00 PM to 7:00 AM shift daily for the ACU/AACU unit. She was to be notified of any scheduling difficulty and a staff member would be mandated to meet the ACU/ACCU staffing schedule. Interviews with the Licensed Practical Nurse (LPN) #7 on 06/02/15 at 9:40 AM, LPN #11, at 9:45 AM, CNA #18 at 9:46 PM, CNA #1 at 2:10 PM, validated there were now two (2) CNAs scheduled for the ACU/AACU on the 11 PM to 7 AM shift. Review of the staffing guidelines, received 06/02/15, revealed one nurse and two CNAs are scheduled for the ACU/AACU for the 11 PM-7 AM shift. Review of the daily staffing sheet from 04/28/15 to 06/02/15 revealed there were one nurse and two CNAs scheduled for the units on the 11 PM-7 AM shift except for 05/03/15. 3. Interview with the Area Vice-President on 06/02/15 at 3:35 PM, revealed she was present at the 04/25/15, the 04/26/15, and the 04/27/15 conference calls for the education of the Behavioral Guidelines and Monitoring log and could validate the Administrator and the Director of Nursing Services was in attendance. Interview with the Field Service Clinical Director on 06/03/15 at 1:35 PM, validated she was the moderator for the education on the Behavior Policy and Guideline Log, on the conference calls, and she attended the Ad Hoc and all Quality Assurance Process Improvement meetings. In addition, she revealed education of the Behavioral Management Guideline Policy was provided to the Director of Nursing Services and Assistant Director of Nursing Services during the quarterly clinical training on 03/26/15.

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	185165	A. BUILDING _____ B. WING _____	**06/03/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - CAMELOT	**1101 LYNDON LANE LOUISVILLE, KY 40222**

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F 0353 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 14) Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the Assistant Director of Nursing Services, on 06/03/15 at 3:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the ACU/ACCU Manager/Director on 06/03/15 at 1:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Telephone interview with the former Administrator, on 05/22/15 at 4:35 PM, revealed he had received training on the Behavior Policy and Log on 04/25/15 from the Field Service Director. In addition, he stated the Director of Nursing Services was assigned to begin education and no employee was allowed to work until they were trained. Record review of the Human Resource employee roster on 06/03/15 revealed, all staff were trained except for: two (2) staff not on schedule, two (2) new hired that began their employment 06/01/15 and were in orientation. Training for behaviors and the behavior log was now part of orientation. Three (3) staff were on Family Medical Leave and one (1) PRN staff had not worked. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed training on the Behavior Policy and log was completed on 04/27/15. Staff that were off received training before their shift. Staff not trained were notified they would not be scheduled to work, until they were trained. In the morning meetings the behavior logs were reviewed. To date one resident on the ACU unit had to be placed on a 1:1 for behaviors. Any resident on [MEDICAL CONDITION] medications or that exhibited behaviors was placed on the behavior log. They are placed in the medication administration binder. Review of the quarterly Clinical Guideline training sign in sheet, dated 03/26/15, revealed the Director of Nursing Services and the Assistant Director of Nursing were trained on the policies by the Field Services Clinical Director. Interview with the Field Services Clinical Director on 06/03/15 at 2:35 PM, revealed the Administrator reports all incidents and [MEDICATION NAME] to her. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed she reports to the Field Services Clinical Director. Review of reportable incidents, on 06/03/15, revealed from 04/23/15 to 05/31/15 the Administrator reported twelve (12) incidents to the Field Services Clinical Director and State Agencies. 4. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed Quality Assurance Improvement Process meetings would be held weekly for four (4) weeks, bi-weekly for four (4) weeks, and then monthly thereafter. At the meetings care plans, behavior log audits, behavior monitoring, investigations, and [MEDICATION NAME] would be discussed. Causative patterns or trigger events and the effectiveness of interventions would be discussed. The behavior log audits would be completed weekly and reported at the meeting by the social worker. Record review on 06/03/15, revealed the Administrator, Director of Nursing Services, Assistant Director of Nursing, Social Services, Director of Education, and the Medical Director were present at an Ad Hoc meeting held 04/27/15 and Quality Assurance Improvement Process meetings on 04/29/15, 05/04/15, 05/14/15, and on 05/21/15.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, it was determined the facility failed to ensure one (1) of two (2) treatment carts on the East Wing were locked. In addition, two (2) of four (4) of the facility's treatment carts contained medications and/or supplies that were opened, out-of-date and/or the resident's name was not readable on a tube of ointment. The findings include: Review of the facility's policy for Storage of Medications, dated May, 2012, revealed medications and biologicals were stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1. Observation of the Treatment Cart on the D Hall, on [DATE] at 12:22 PM, revealed the treatment cart was unlocked. Residents were observed leaving the dining room ambulating and self-propelling in wheelchairs. Residents passed by the treatment cart; however, no resident was observed to open the treatment cart. Observation of the contents of the treatment cart, on [DATE] at 12:25 PM, revealed tubes of medicated creams and ointments including: Silvasorb Wound Gel; Zinc Oxide; Medisca Hydrogel; Benadryl Cream; Bacitracin Ointment; Kitoconazole Cream; Saf-Clens AF Spray; and, Risamins Ointment were present inside the cart. Review of the drug information for Allegro Medical, the company that made Silvasorb, revealed Slivasorb Wound Gel was for external use and not to be ingested or placed on eyes or in nose. Review of the Mayoclinic.com website, revealed Zinc Oxide was for use on skin only and if accidentally ingested, call Poison Control immediately. Interview with the Treatment Nurse/Licensed Practical Nurse (LPN) #1, on [DATE] at 12:35 PM, revealed he had not used the treatment cart that day. He stated the cart should be locked at all times unless supplies were being removed from the cart for treatments. He stated the cart was locked earlier when he checked it. LPN #1 stated there were medications in the cart that were dangerous and could harm residents if the residents ingested them. Interview with the East Wing Unit Manager (UM), on [DATE] at 12:41 PM, revealed the other nurses on the unit had not used the cart that day. She stated residents could easily open the cart drawers and ingest the creams and ointments. She stated all the nurses had keys to the cart; however, the Treatment Nurse/LPN #1 was usually the person using the cart. She stated many residents on the unit were confused and mobile. Interview with the Director of Nursing Services (DNS), on [DATE] at 3:14 PM, revealed the Treatment Cart should be locked at all times to prevent residents from ingesting the medications and being harmed. She stated she did check the carts on occasion. 2. Observation, on [DATE] at 8:15 AM, of the contents of the treatment cart on the facility's East Wing-1, revealed a container of chlorine bleach disinfectant wipes (150 count), with an expiration date of [DATE]. Observation, on [DATE] at 8:20 AM, of the contents in the treatment cart on the facility's East Wing-2, revealed a 22 Gram (GM) tube of 2% Mupirocin Ointment that was uncapped. The resident identification label on the tube of Mupirocin Ointment was so faded that the resident's name was not ledgeable. In addition, one long cotton-tipped applicator was open in the top drawer, and one other cotton-tipped applicator, in a ripped open package, was also in the top drawer of the treatment cart. Interview, on [DATE] at 8:25 AM, with Treatment Nurse/LPN #1, revealed he used the bleach wipes found on the East Wing-1 treatment cart to clean the exterior of the cart every other day. Treatment Nurse/LPN #1 stated bleach wipes that had been expired for nearly a year may not be effective for sanitizing surfaces. Interview, on [DATE] at 8:50 AM, with the Central Supply Staff, revealed the facility used a case of bleach/disinfectant wipes about every three (3) weeks, and when the facility received new shipments, he was responsible for opening the cases to ensure the supplies were in-date. If not, he contacted the supplier and shipped out-of-date items back for replacement or reimbursement. Interview, on [DATE] at 11:50 AM, with the East Wing UM revealed all nurses assigned to treatment carts were responsible for checking the expiration dates on supplies and medications before use. If the package seals were broken open, those items should be discarded because they would no longer be considered clean and could pose a risk for cross-contamination, if used. The UM stated the 2nd shift nurses were responsible for cleaning the carts and inspecting the contents for cleanliness and organization, and should dispose of potentially contaminated supplies and/or out-of-date items. In addition, the UM stated creams and ointments should always be appropriately stored (capped) and clearly labeled with the resident's name. Interview, on [DATE] at 1:55 PM with the DNS, revealed the nurses assigned to clean the residents' treatments were responsible for ensuring all supplies in the treatment carts were in-date, and that the carts never contained opened/damaged supplies or uncapped/unsealed medications. The DNS stated expired bleach wipes could be potentially

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F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 15) ineffective. The DNS stated the night shift (11 PM-7 AM) staff was responsible for weekly cleaning of the treatment carts. In addition, the night shift nurses were also responsible for removing damaged/opened supplies and for ensuring each cart's contents were organized and properly stored and labeled. Continued interview with the DNS revealed the nurses were aware of the importance of ensuring supplies were properly stored and in-date, but she did not have formal audit tools that documented the treatment cart inspections by the night shift nurses. The DNS stated the problem with storing opened supplies and uncapped medications/ointments was these items may be unclean and would pose a risk for transmitting infections. The DNS stated potentially contaminated supplies should never be in the treatment carts, and available for use.
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 for catheter insertion, hand hygiene, contact precautions, and wound dressing, it was determined the facility failed to ensure their infection control program was implemented consistently for four (4) of twenty-nine (29) sampled residents (Residents #1, #4, #7, and #21). Treatment Nurse/Licensed Practical Nurse #1 failed to maintain clean technique and perform hand hygiene during Residents #1's and 4's wound dressings. Resident #1 (who had a roommate with a gastrostomy tube) was not placed in contact precautions for Methicillin-Resistive Staphylococcus Aureus (MRSA). LPN #5 failed to use aseptic technique during a catheterized for Resident #7; and, Resident #21's indwelling catheter was observed on the floor. The findings include: Review of the facility's policy titled Catheter Insertion and Removal, review date of 01/26/15, revealed a sterile catheterization tray was to be used. A sterile wrap was to be used to create a sterile field. The nurse was to put on sterile gloves and drape the resident with a sterile drape. Cleanse directly over the urinary meatus with a clean wipe, using circles from the meatus outward. Discard the wipe after each circle. After cleaning, apply lubricate to the tip of the catheter. Insert the catheter into the urinary meatus. 1. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 01/20/14 with [DIAGNOSES REDACTED]. Further review revealed the resident was under the care of an Urologist that ordered for the resident to be catheterized (in and out) four (4) times a day. The clinical record revealed the resident experienced several chronic Urinary Tract Infections (UTI) in January and February 2015 and was recently treated with antibiotic medication for a UTI on 04/09/15. Observation, on 04/23/15 at 11:25 AM, revealed LPN #5 assisted Resident #7 to the bathroom to urinate and then assisted the resident to the bed. The nurse removed the resident's pants and brief. The resident's brief was soiled with a small amount of feces. The nurse disposed of the soiled brief, but did not provide incontinent care. The nurse then washed her hands and applied clean gloves. The nurse stated she would use aseptic technique for the catheter insertion. LPN #5 opened the sterile catheterization kit and placed the container on the resident's bedside table. The table had not been cleaned and no sterile field had been created. The nurse opened the package of sterile gloves and applied them. LPN #5 proceeded to cleanse the urinary meatus with a [MEDICATION NAME] swab, touching the resident's inner thigh. She removed the swab and threw it into the paper container that the sterile gloves came in. The other clean [MEDICATION NAME] swabs were placed on the paper too. The nurse took another swab and cleansed the urinary meatus outside first. The nurse placed the used swab onto the paper with the other clean swab. The nurse then took the third swab and cleaned the inner part of the meatus. The nurse placed that used swab onto the paper with the others. She then attempted to catheterize the resident after application of a lubricate. The nurse could not obtain urine return and after several attempts had to stop. She removed the catheter and placed a clean brief on the resident without incontinent care. Interview with LPN #5, on 04/23/15 at 11:50 PM, revealed she normally did not provide a sterile barrier field and would place supplies onto the sterile gloves package. LPN #5 stated she had not cleaned the resident after removal of the soiled brief. She stated it was such a small amount of feces and she had placed the sterile pad under the resident's buttocks. Further observation revealed she failed to drape the resident before the procedure. She stated that was how she always performed the catheterizations and she did not use the drape from the sterile catheterization kit. She indicated she had been taught on the procedure in nursing school, but she did not think that procedure was included in the annual competency skills at the nursing facility. Review of the facility's 2015 annual education calendar revealed infection control (USS-7000) was to be presented in July 2015. This was a computer online learning module. Review of the content of the training revealed catheter insertion was not included. Review of LPN #7's training records revealed the nurse was observed performing indwelling catheter care on 03/08/13. However, there was no evidence the nurse had received any type of training regarding proper insertion of a catheter. Interview with the Clinical Educator/Infection Control Nurse, on 04/24/15 at 7:54 AM, revealed staff including nurses were trained using online modules. She stated the Corporation had required specific monthly in-service education but they picked the topic, not her. She stated the nurses must complete an annual competency training which included skill check offs. However, the last check off on skills with return demonstration was in April 2014. She indicated she could not schedule a training without permission from the Corporation because they do all the scheduling of training without her input. She stated she had not been told to conduct a training on catheterization. 2. Review of the facility's policy for Multidrug-Resistant Organisms (MDRO), dated August 2014, revealed the facility would take appropriate precautions when caring for residents with MDRO. The use of Contact Precautions will be determined on a case by case basis. Residents with a risk for transmission included residents with total dependence for activities of daily living may require contact precautions. A resident with a MDRO may need to be separated from a roommate who had a gastrostomy feeding tube. Review of the clinical record for Resident #1, revealed the facility admitted the resident on 08/22/14, with [DIAGNOSES REDACTED]. The resident developed gangrene in the right foot resulting in amputation of the right, great and second toes. The resident was readmitted following the amputation, on 04/14/15, with [DIAGNOSES REDACTED]. Review of the clinical record for Resident #1, revealed the facility completed a Significant Change Minimum Data Set assessment for Resident #1, on 03/26/15, which revealed the resident was cognitively impaired. The resident required extensive assistance with care, total care with bathing and was incontinent of bowel and bladder. Review of the care plan for Resident #1, revealed the resident received an intravenous antibiotic daily for the wound infection and Wound V.A.C. Therapy was used to treat the surgical wound. This wound treatment was completed every three (3) days. Observation of Resident #1, on 04/21/15 at 9:10 AM, during the initial facility tour, revealed the resident in bed in the room. The resident had a Wound V.A.C. attached to the right foot. Interview with the Director of Clinical Education, on 04/22/15 at 9:12 AM, revealed the resident had an amputation of the right great and second toe and had Methicillin-Resistant Staphylococcus Aureus (MRSA) in the wound and received intravenous antibiotic therapy. She stated she was aware of the facility's policy on Contact Precautions; however, the Director of Nursing determined the resident's wound was contained by the Wound V.A.C. and there was no need for any Contact Precautions. She stated this was the facility's policy per the Director of Nursing Services. She stated Resident #1's roommate had a gastric tube. Observation of Resident #1, on 04/21/15 at 11:40 AM, revealed the resident had been moved to a private room and Contact Precautions were in place 3. Review of the facility's policy for Clean Wound Dressing Change, effective date 03/10/15, revealed the nurse was to create a clean field with paper towels or a drape. The policy instructed the nurse to remove gloves when finished with the procedure and wash hands after removal of the soiled gloves. Observation of Treatment Nurse/LPN #1, during the change of Resident #1's dressing, on 04/22/15 at 2:22 PM, revealed the Treatment Nurse/LPN #1 donned a gown, gloves and a mask prior to entering the resident's room. He placed sterile dressings on the overbed table and opened them without the overbed table being sanitized and a clean field being established. He discontinued the Wound V.A.C. Therapy and removed the soiled dressing. He washed his hands and re-gloved. Measurements of the wound were taken by the nurse and included the depth of the wound. The paper tape measure touched the edge of the wound

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 16) when he measured the length of the wound. He then reached under his gown and removed a pen from his shirt pocket to record the wound measurements without removing his gloves and hand washing or sanitizing. Further observation revealed when the LPN finished recording the measurements, he tossed the paper tape onto the clean dressing supplies. LPN #1 also failed to provide a clean field for the resident's foot during the application of the clean dressing. The nurse reached inside his gown and removed scissors from his pant pocket and proceeded to cut the foam dressing to the size of the wound. During this time, the nurse's gown was falling off his shoulders. He stopped the dressing and pulled the gown up and tied the strings at the shoulder and waist to secure it. He then continued with the clean dressing. Interview with the Treatment Nurse/LPN #1, on 04/23/15 at 10:48 AM, revealed he had numerous in-services regarding infection control and wound care. He stated he had a bad day on 04/22/15 and so he did not do a good job during the dressing change for Resident #1. He stated he used the V.A.C. Whitefoam Dressing Application Instructions as the policy for dressing changes. He stated the wound was not contained during the dressing change, so the resident should have been in contact precautions. He further stated per the Director of Nursing Services, residents were no longer placed in contact precautions. He stated he did not think about the resident's roommate having a gastric tube and he did not know what the policy said regarding contact precautions not being in the same room with a resident with a tube, including gastric tubes. He stated clean fields should have been established for the clean dressings and under the resident's foot while applying the clean dressings. He stated he made mistakes and did not wash/sanitize his hands when going from soiled to clean tasks and that included using soiled gloves to remove equipment from his uniform. He stated the Director of Nursing visually saw each wound weekly and had mentioned several times concerns with his technique. However, she did not provide additional education or supervision of his performance. He stated cross contamination could cause other residents to be infected, especially sicker residents. Interview with the Director of Nursing Services (DNS), on 04/23/15 at 11:25 AM, revealed she saw every resident with a wound weekly. She stated the Treatment Nurse/LPN #1 should have set-up a clean field for dressing supplies by sanitizing the overbed table or by using soap and water to clean the overbed table prior to placing a clean barrier and opening sterile supplies. She stated hand sanitation should be completed when moving from a dirty task to a clean task. The DSN stated she had observed issues with infection control and not changing gloves in the past and she had addressed those issues. However, she could not provide any written evidence of educating or counseling Treatment Nurse/LPN #1 regarding infection control practices. In addition, the DNS stated she had no audit tool to use when observing wound care. She indicated bacteria could be transmitted to other residents and staff when infection control practices were not followed. The DSN stated contact precautions were not necessary for residents with multiple drug resistant organisms (MDRO) infections if the infection was contained. She stated Resident #1's MRSA infection of the foot was contained by the Wound V.A.C. except during dressing changes. She stated Resident #1's roommate with a gastric tube was missed and residents with tubes should not be in rooms with residents with MDRO infections. She stated she was aware that Resident #1 had MRSA in the surgical wound, but missed having staff place the resident in contact precautions as he/she should have been. 4. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 07/15/14 with [DIAGNOSES REDACTED]. The resident received daily treatment for [REDACTED]. Observation of wound care treatment for [REDACTED].#1, on 04/22/15 at 3:05 PM, revealed the nurse did not create a clean field for the treatment supplies used for the wound care and dressing change. Treatment Nurse/LPN #1 washed his hands and donned clean gloves. Further observation revealed the LPN removed the old dressings from the bottom of Resident #4's right foot and heel. The wound on the bottom of the foot revealed a small amount of clear drainage. Treatment Nurse/LPN #1 measured the wounds. After he measured the wounds, he did not remove his gloves and wash his hands before leaving the room to retrieve cotton applicators from the treatment cart. Treatment Nurse/LPN #1 opened the door of the room with his gloved hand and exited the room. Further observation revealed Treatment Nurse/LPN #1 used his gloved hands for the following: he unlocked the treatment cart with the treatment cart key; opened a drawer of the cart; retrieved the cotton applicators; closed the drawer; locked the cart; and re-entered the room and closed the door by use of the door handle. Continued observation revealed after Treatment Nurse/LPN #1 re-entered the room, Treatment Nurse/LPN #1 did not remove his gloves and wash his hands prior to cleansing and dressing the resident's wounds. Interview, on 04/22/15 at 3:45 PM, with Treatment Nurse/LPN #1 revealed he was not aware that he left his gloves on when he exited Resident #4's room. Treatment Nurse/LPN #1 stated he touched the door knobs, keys, and the treatment cart with dirty gloves which could spread infection. Further interview with Treatment Nurse/LPN #1, on 04/23/15 at 10:45 AM, revealed a clean area should be used for treatment supplies. He further stated after removing the old dressings, hand hygiene should be performed and new gloves donned prior to cleansing the wound. He reported in-services were provided by the Director of Clinical Education on how to use sterile techniques and how to contain infections. Interview with the Director of Clinical Education, on 04/23/15 at 8:40 AM, revealed the facility required in-services to be done annually. She stated the employees were required to access learning modules on the computer. She further stated she monitored infection control by working the floor four (4) to five (5) days a month. If concerns were identified, education was conducted with direct care staff as a group in the morning meetings and throughout the day individually. Interview with the Director of Nursing Services, on 04/23/15 at 11:10 AM, revealed she regularly monitored wounds and had observed dressing changes done by Treatment Nurse/LPN #1. She stated she had observed the nurse not performing hand hygiene between dirty and clean and had to remind him to changes his gloves. She stated when concerns were identified, education was provided on the spot; but, this was not documented. The DSN stated the bedside tables should be cleaned before supplies were laid on them. She stated there was not an audit tool in place to monitor for infection control during dressing changes. 5. Review of the facility's Preventing Catheter Associated Urinary Tract Infections policy, dated 01/06/15, revealed the drainage bag was not to be placed on the floor. Review of the clinical record for Resident #21 revealed the facility admitted the resident on 03/26/15 with the [DIAGNOSES REDACTED]. Observation of Resident #21, on 04/22/15 at 5:00 PM, revealed the resident had an indwelling catheter to a bed side drainage. The catheter drainage bag was in a dignity bag that was in direct contact with the floor. Continued observation of Resident #21, on 04/23/15 at 7:25 AM, revealed the resident's dignity bag containing the catheter drainage bag was lying on the floor beside the resident's bed. Interview with the Director of Clinical Education, on 04/23/15 at 8:40 AM, revealed the facility required in-services to be done annually. She stated the employees were required to access learning modules on the computer. The nurses on the floor were responsible for monitoring that the indwelling catheter bags were positioned below the bladder and off the floor. She further stated if a concern was identified, education would be provided to the direct care staff as a group in the morning meetings and individually throughout the day. Interview with CNA #3, on 04/23/15 at 2:30 PM, revealed catheter bags were kept in dignity bags and they should never touch the floor. She stated if a bag touched the floor it could lead to infections. CNA #3 stated in-services on infection control were done regularly. Interview with LPN #3, on 04/23/15 at 1:30 PM, revealed an indwelling catheter drainage bag should not have contact with the floor because it could put the resident at risk for infection. She further stated she monitored to make sure catheter drainage bags were hung from wheel chairs and beds without touching the floor. LPN #3 stated in-services on infection control were done in person and on the computer. Interview with the Unit Manager, on 04/23/15 at 2:40 PM, revealed indwelling catheter drainage bags should be kept off the floor to prevent them from becoming contaminated which could lead to an infection. She further stated she monitored indwelling catheters when she rounded on the floor. If a catheter bag was found to be in contact with the floor, she would immediately educate the direct care staff.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policies, it was determined the facility's Administrator failed

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	185165	A. BUILDING _____ B. WING _____	06/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 17) to have an effective system to ensure the facility policies and procedures were implemented to monitor residents with behaviors and to provide adequate supervision to protect all residents in the locked Alzheimer's Care Units. In addition, the Administration failed to utilize resources (corporate policy and guidelines for behaviors) and failed to provide adequate staffing for adequate supervision of residents with identified Sexual Acting Out (SAO) behaviors. On 03/11/15 at 5:50 AM, the facility staff observed Resident #10 sitting on a couch next to Resident #18 sucking on his/her right breast. The clinical record identified the resident to have a history of fondling, touching other residents, and exposing self to others. The resident required hospitalized from [DATE] to 03/24/15. Review of the hospital Intake Coordinator's documentation revealed Resident #10's SAO behaviors presented a threat of harm to other residents. Review of the facility's staffing for 03/11/15 revealed one nurse and one nurse aide was scheduled to care for thirty-one residents. Interview with Registered Nurse #6, on 04/23/15 at 1:45 PM, revealed there were two locked units, the Alzheimer's Care Unit (ACU) and the Advance Alzheimer's Care Unit (AACU). She revealed she and the nurse aide were on the ACCU at the same time of the incident leaving the ACU with fifteen (15) residents unsupervised. The facility's failure to monitor Resident #10's SAO behaviors and provide adequate supervision resulted in an unsafe environment for other residents. Interview and record review revealed the facility failed to implement their policy and procedures related to behaviors, staffing, revision/implementation of care plans, and maintaining accurate clinical records. (Refer to F-280, F-323, F353, and F-514). The facility Administration's failure to administer effectively has caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 03/11/15. An Acceptable Allegation of Compliance (AOC) was received on 05/28/15 which alleged removal of the Immediate Jeopardy on 05/28/15. The State Survey Agency determined the Immediate Jeopardy was removed on 05/28/15 prior to exit of the survey on 06/03/15. The scope and severity was lowered to a D while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes The findings include: Review of the facility's policy regarding Behavior Management Guideline, dated 02/12/15, revealed the facility was to develop behavior plans and medication regimens to optimize the functional abilities of residents while monitoring for adverse side effects and improved behaviors. The facility was supposed to utilized the Antecedent Behavior Monitoring Log for residents with behaviors that negatively affect functioning or quality of life. The Behavior Committee members were to review the log to identify patterns and causative triggering events for the behaviors and to measure the effectiveness of interventions. Additionally, the policy stated when the facility used an antipsychotic medication to treat an enduring condition; the facility must clearly and specifically identify and document the target behaviors. The facility must have clear documented evidence in the medical record that the situation or condition continued or recurred over time and the behaviors negatively affected the resident's quality of life. Review of the Corporate guidelines for Communication and Documentation of an Event, dated 02/10/10, defined an event as an incident that resulted in, or had the potential to result in, physical or mental harm to a resident. Per the guidelines, an event included resident-to-resident altercations and demonstrated high-risk patient behaviors or situations. When an event occurred, the facility was always to complete a thorough and objective Verification of Investigation form. Interview with the Administrator, on 04/22/15 at 4:00 PM, revealed he was informed of the incident between Residents #10 and #18 on 03/11/15. He stated he met with the Director of Nursing Services (DNS) and they decided it was not a reportable incident, it was just behaviors. However, review of the Corporate guidelines for Communication and Documentation of an Event revealed an event included resident-to-resident altercations and demonstrated high-risk patient behaviors or situations. He stated no investigation was conducted regarding the residents' behaviors because Resident #10 was placed on 1:1 supervision and then transferred to a Psychiatric Hospital for treatment. However, per the Corporate guidelines, the facility was always to complete a through and objective investigation when an event occurred. Continued interview with the Administrator revealed Resident #18's family was aware of the incident and had no concerns. The Administrator stated neither he nor the DNS looked at staffing and he was unaware the residents were left unsupervised because of staffing issues. The Administrator stated he did not discuss the SAO behaviors (or any behaviors) during the monthly QA meetings with the facility staff and had not discussed this with the Medical Director. He stated behaviors had not been a routine topic discussed at the quarterly QA meetings; just discussion of [MEDICAL CONDITION] medication use. Further interview with the Administrator, on 05/06/15 at 10:53 AM, revealed the facility did not utilize the Antecedent Behavior Monitoring Log before the Immediate Jeopardy. However, per the facility's policy Behavior Management Guideline, the facility was supposed to utilized the Antecedent Behavior Monitoring Log for residents with behaviors that negatively affect functioning or quality of life. He further stated the log was available in the Corporate policies on-line and he was to utilize the form; however, neither he or the DNS had implemented the form, per the facility's policy. Therefore, the Behavior Committee did not review residents' behaviors at the weekly meetings according to the Corporate policy. He stated he could not recall when the Behavior Management Guidelines went into effect and could not recall if he received an e-mail regarding the new policy as was the practice of the Corporation. Additional interview with the Administrator, on 05/22/15 at 4:35 PM, revealed he was unaware of either of the Behavior Monitoring and Management policies. He had no system in place for documenting and monitoring residents' behaviors. In addition, he stated monitoring and documentation for resident behaviors was a nursing function. Interview with the Field Services Clinical Director on 06/03/15 at 1:15 PM, revealed on 03/26/15 at the quarterly Clinical Guideline training, she reviewed all on-line policies with the Director of Nursing and the Assistant Director of Nursing. In addition she said all incidents and [MEDICATION NAME] were reported to her by the Administrator. However, interviews with the Administrator and Director of Nursing revealed they did not think the incident was reportable. Review of the daily census, dated 03/11/15, revealed the Alzheimer's Care Unit (ACU) and the Advanced Alzheimer's Care Unit (AACU) had thirty-one (31) residents on the units combined. Review of the facility's staffing for the night shift (11 PM-7:00 PM) on 03/11/15, revealed one nurse and one nurse aide was scheduled to care for the thirty-one residents. Interview with Registered Nurse #6, on 04/23/15 at 1:45 PM, and Certified Nursing Assistant (CNA) #12 on 05/05/15 at 9:40 PM revealed on the morning of the incident (03/11/15) both staff were on the ACCU and left the ACU unsupervised. Both employees stated they were aware of Resident #10's SAO behaviors. Refer to F323. Additional interviews with CNA #13, on 05/05/15 at 3:55 PM, and CNA #14, on 05/05/15 at 4:14 PM, revealed they could not supervise both the ACU and the AACU at the same time with only one nurse and one CNA working the units at night. The CNAs stated they could not visually see both units unless she was in the nurses' station, and then she could only see the front half of the ACU. CNA #13 stated residents would frequently get up in the night and several residents would wander into other residents' rooms. She stated there were times when the nurse and the aide had to be on the same unit at the same time, leaving the other unit unsupervised. Record review revealed Resident #10 exhibited SAO behaviors on 06/06/14, 08/12/14, 12/20/14, 01/12/15, 01/30/15, and 02/06/15. However, the supervision of the resident was not increased unless the resident exhibited a SAO behavior and then for a very short time. However, interview with the ACU Manager, on 04/23/15 at 11:00 AM, revealed she had failed to document in the clinical record what specific behaviors the resident was exhibiting on 01/30/15 that required closer supervision of the resident. The Unit Manager indicated nursing did not always document behaviors in the clinical record. Refer to F514. The facility took the following actions to remove the Immediate Jeopardy on 05/28/15 by implementing the following: 1. Resident #10 was separated from the female residents and placed in sight of staff until transferred to a behavior unit for treatment on 03/11/15. Resident #10's documentation was noted in the Caretracker and Point Click Care by the Unit Manager on 04/26/15. On 03/11/15 the Charge Nurse and Certified Nursing Assistant took immediate action to ensure the safety of other residents by closely monitoring Resident #10 until transfer to the behavior treatment unit at approximately 5:20 PM. No other behaviors occurred. 2. On 04/28/15, The Nursing Home Administrator and Director of Nursing Services discussed staffing patterns in the Alzheimer's Care Unit (ACU) and Advanced Alzheimer's Care Unit (AACU) on the 11-7 shift. It was determined one Certified Nursing Assistant was added to the 11 PM-7 AM shift on the Alzheimer's Care Unit.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 18) 3. On 04/25/15 and 04/26/15 conference calls were conducted with the Administrator and Director of Nursing Services. The facility's Health Care Council guided the Administrator and the Director of Nursing Services through the location on the Policy Center and existence of behavior monitoring guidelines and log. The Area Vice-President and Field Services Clinical Director were present for both calls. On 04/27/15 the Field Services Clinical Director provided additional education to the Administrator, Director of Nursing Services, Assistant Director of Nursing, ACU/AACU Director, Director of Clinical Education, and Social Services Director on behavior management guidelines and monitoring. The Director of Nursing Services and Assistant Director of Nursing Services received education on the Behavioral Management Guideline Policy, on 03/26/15, during the quarterly clinical guideline training hosted by the Field Services Clinical Director. On 04/25/15, the Administrator received education related to the Behavior Guideline and Monitoring by the Health Care Council. The Administrator ensured the Director of Nursing Services began education and no employee would work unless they received the education. The Administrator monitored progress at least daily in the Clinical Start-Up meeting at least daily. On 04/27/15, the Files Services Clinical Director provided additional education to the Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education, ACU/AACU Director, and Social Services Director on behavioral management guidelines and behavior monitoring and charting. On 04/27/15, the Administrator consulted with the Field Services Clinical Director for investigations and incidents that may result as a reportable. There were two (2) incidents reported in April and eight (8) incidents reported in May. 4. An Ad Hoc Quality Assurance Process Improvement meeting, consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Director of Education and the Medical Director by phone was held on 04/27/15 to discuss the event of 03/11/15 and to develop a plan to prevent reoccurrence. The behavioral management guidelines and monitoring plan that the facility had implemented was discussed with the Medical Director via phone. A Quality Assurance Process Improvement Committee meeting will be held weekly x 4 weeks, then monthly thereafter. The committee will review results of the care plan and behavior log audits, behavior monitoring, and any investigations or [MEDICATION NAME]. The Behavior Monitoring Log is utilized for residents who are exhibiting behaviors. The audit identifies patterns and positive or triggering events and effectiveness of interventions. The audits will be completed weekly by the Social Worker and Director of Nursing Services and/or Assistant Director of Nursing Services. The Administrator held Quality Assurance Process Improvement meetings to review behavior care plan logs, audits, [MEDICATION NAME], and investigations on 05/04/15, 05/14/15, 05/21/15. The State Survey Agency validated the removal of Immediate Jeopardy on 06/03/15 prior to exit as follows: 1. Interview with Licensed Practical Nurse #13, on 06/01/15 at 2:55 PM, revealed until Resident #10 was transferred to a local behavioral unit he/she was kept in staff view. Review of Caretracker and Point Click Care revealed the resident was placed on 1:1 supervision until transferred on 03/11/15. Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed Resident #10 was placed on observations for the safety of ACU/AACU residents. Review of the Discharge Summary from the behavior unit on 06/02/15 revealed, Resident #10 was admitted for evaluation on 03/11/15 and discharged on [DATE] back to the facility. Interview with Licensed Practical Nurse #7, on 06/02/15 at 6:25 AM, revealed on the morning of 03/11/15 she separated the residents without difficulty and reported the incident to the House Supervisor. She stayed with the female resident and the male resident was taken to his room. Resident #10 was then monitored. 2. Interview with the Director of Nursing on 06/03/15 at 8:30 AM, revealed the staffing schedule was revised to include two (2) Certified Nursing Assistants were now scheduled on the 11:00 PM to 7:00 AM shift daily for the ACU/AACU unit. She was to be notified of any scheduling difficulty and a staff member would be mandated to meet the ACU/ACCU staffing schedule. Interviews with the Licensed Practical Nurse (LPN) #7 on 06/02/15 at 9:40 AM, LPN #11, at 9:45 AM, CNA #18 at 9:46 PM, CNA #1 at 2:10 PM, validated there were now two (2) CNAs scheduled for the ACU/AACU on the 11 PM to 7 AM shift. Review of the staffing guidelines, received 06/02/15, revealed one nurse and two CNAs are scheduled for the ACU/AACU for the 11 PM-7 AM shift. Review of the daily staffing sheet from 04/28/15 to 06/02/15 revealed there were one nurse and two CNAs scheduled for the units on the 11 PM-7 AM shift except for 05/03/15. 3. Interview with the Area Vice-President on 06/02/15 at 3:35 PM, revealed she was present at the 04/25/15, the 04/26/15, and the 04/27/15 conference calls for the education of the Behavioral Guidelines and Monitoring log and could validate the Administrator and the Director of Nursing Services was in attendance. Interview with the Field Service Clinical Director on 06/03/15 at 1:35 PM, validated she was the moderator for the education on the Behavior Policy and Guideline Log, on the conference calls, and she attended the Ad Hoc and all Quality Assurance Process Improvement meetings. In addition, she revealed education of the Behavioral Management Guideline Policy was provided to the Director of Nursing Services and Assistant Director of Nursing Services during the quarterly clinical training on 03/26/15. Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the Assistant Director of Nursing Services, on 06/03/15 at 3:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the ACU/ACCU Manager/Director on 06/03/15 at 1:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Telephone interview with the former Administrator, on 05/22/15 at 4:35 PM, revealed he had received training on the Behavior Policy and Log on 04/25/15 from the Field Service Director. In addition, he stated the Director of Nursing Services was assigned to begin education and no employee was allowed to work until they were trained. Record review of the Human Resource employee roster on 06/03/15 revealed, all staff were trained except for: two (2) staff not on schedule, two (2) new hired that began their employment 06/01/15 and were in orientation. Training for behaviors and the behavior log was now part of orientation. Three (3) staff were on Family Medical Leave and one (1) PRN staff had not worked. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed training on the Behavior Policy and log was completed on 04/27/15. Staff that were off received training before their shift. Staff not trained were notified they would not be scheduled to work, until they were trained. In the morning meetings the behavior logs were reviewed. To date one resident on the ACU unit had to be placed on a 1:1 for behaviors. Any resident on [MEDICAL CONDITION] medications or that exhibited behaviors was placed on the behavior log. They are placed in the medication administration binder. Review of the quarterly Clinical Guideline training sign in sheet, dated 03/26/15, revealed the Director of Nursing Services and the Assistant Director of Nursing were trained on the policies by the Field Services Clinical Director. Interview with the Field Services Clinical Director on 06/03/15 at 2:35 PM, revealed the Administrator reports all incidents and [MEDICATION NAME] to her. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed she reports to the Field Services Clinical Director. Review of reportable incidents, on 06/03/15, revealed from 04/23/15 to 05/31/15 the Administrator reported twelve (12) incidents to the Field Services Clinical Director and State Agencies. 4. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed Quality Assurance Improvement Process meetings would be held weekly for four (4) weeks, bi-weekly for four (4) weeks, and then monthly thereafter. At the meetings care plans, behavior log audits, behavior monitoring, investigations, and [MEDICATION NAME] would be discussed. Causative patterns or trigger events and the effectiveness of interventions would be discussed. The behavior log audits would be completed weekly and reported at the meeting by the social worker. Record review on 06/03/15, revealed the Administrator, Director of Nursing Services, Assistant Director of Nursing, Social Services, Director of Education, and the Medical Director were present at an Ad Hoc meeting held 04/27/15 and Quality Assurance Improvement Process meetings on 04/29/15, 05/04/15, 05/14/15, and on 05/21/15.
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards**

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 19) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure clinical records were accurate and complete to ensure documentation of sexual acting out behaviors and Physician order [REDACTED].#10 and #29). Record review and interviews revealed on 03/11/15 at 5:50 AM, the facility staff observed Resident #10 sitting on a couch in the Alzheimer's Care Unit (ACU) next to Resident #18 sucking on his/her right breast. Interviews with nurses and Certificated Nursing Assistants (CNAs) revealed Resident #10 had history of sexually acting out behaviors (SAO). On 02/06/15, the facility had consulted with the Psychiatrist due to Resident #10 becoming more inappropriate with touching other residents and staff. However, the clinical record did not reflect this. In addition, the facility staff documented the resident was placed on every fifteen (15) minute checks, but did not document in the clinical record what behaviors the resident was exhibiting that warranted close supervision. After Resident #10's readmission to the facility on [DATE] from a psychiatric hospitalization , the facility failed to place the hospital discharge information into the clinical record for continuation of care. The facility failed to place telephone orders signed by the physician into the clinical record for Resident #29. The staff failed to obtain Resident #29's weights as ordered by the physician. The facility's failure to have an effective system in place to ensure clinical records were accurate and complete placed residents in a situation that has caused, or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was identified on 04/24/15 and was determined to exist on 03/11/15. The facility provided an acceptable Allegation of Compliance (AOC) on 04/29/15 which alleged removal of the Immediate Jeopardy on 04/29/15. The State Survey Agency verified Immediate Jeopardy was not removed on 04/29/15 as alleged, but on 05/07/15 prior to exit. The Scope and Severity was lowered to a D while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy manual regarding Health Information Management Manual: Policies, Procedures, and Guidelines for Medical Records Maintenance, dated 10/07/13, revealed the facility would ensure the medical records contained sufficient information to demonstrate the resident's current condition and provide evidence the facility was providing care per the care plan. The policy stated the purpose of the medical record was to provide information for the evaluation of the quality and effectiveness of the care provided. The facility was to have chronologically documented the events surrounding resident care and should include observation and description of significant changes in condition, provision of care, and response to care. The policy went on to state the Nursing Progress Notes should contain a complete record of nursing care provided. The nursing documentation should occur often enough to tell the whole story. Nursing Progress Notes should include changes in behavior, incidents, or accidents involving the resident, and documentation of behavioral interventions. Nursing Progress Notes should also contain a record of the resident's response to care provided. Review of the facility's policy regarding Behavior Management Guideline, dated 02/12/15, revealed the facility would utilize the Antecedent Behavior Monitoring Log for residents with behaviors that negatively affect functioning or quality of life. The facility must have clearly documented evidence in the medical record that the situation or condition continued or recurred over time and the behaviors negatively affected the resident's quality of life. In order to monitor, the facility would establish a monitoring system for targeted behaviors, interventions, medication effectiveness, and side effects. Review of the Corporate Guidelines for Communication and documentation of an event, dated 02/10/10, defined an event as an incident that resulted in, or had the potential to result in physical or mental harm to a resident. Per the Guidelines, an event included resident-to-resident altercations and demonstrated high-risk patient behaviors or situations. When an event occurred, the facility was always to complete a thorough and objective Verification of Investigation. 1. Review of Resident #10's clinical revealed the facility admitted the resident on 04/08/12 with [DIAGNOSES REDACTED]. The resident was receiving anti-depressant medications, anti-psychotic medications, and hormone medications. Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 04/13/15, revealed the facility assessed the resident as requiring only supervision or limited assistance to complete Activities of Daily Living (ADL). The resident was able to transfer and walk in the corridor with supervision only. Continued review of Resident #10's clinical record of a Progress Note, dated 06/06/14 at 11:29 AM, revealed the ACU Manager documented the Psychiatrist met with Resident #10 on 06/06/14. The Psychiatrist's Note revealed the resident had sexually inappropriate behaviors toward staff including touching female staff in inappropriate places. However, the Nurse's Notes reviewed from 04/30/14 through 06/06/14 revealed no documentation of Resident #10 exhibiting SAO behaviors or interventions for the SAO behaviors, or that any interventions were implemented as directed by the facility's policy. Review of the Psychiatric Consult/Follow-Up, dated 08/12/14, revealed the facility consulted with the Psychiatrist. Under reason for the visit, the Psychiatrist documented the resident continued to inappropriately touch females' (staff and peers) buttocks and breasts. The Consult further stated the behaviors were impulsive and the resident was unable to remember any of these behaviors. However, the Nurse's Notes from 07/16/14 through 08/11/14 revealed no documentation of Resident #10 exhibiting SAO behaviors or of staff using interventions for SAO behaviors. A Nursing Note, on 08/12/14 at 8:45 AM, revealed staff observed Resident #10 hugging a female resident. Review of the Progress Notes, dated 12/20/14 at 1:18 AM, revealed the facility documented they had placed Resident #10 on fifteen (15) minute checks due to sexual behaviors. The Progress Note did not indicate what SAO behaviors the resident exhibited to warrant the facility placing him/her on every fifteen (15) minute checks. The Progress Notes did not indicate what interventions the facility used when the SAO behaviors occurred or what interventions the facility was using to prevent reoccurrence of the behavior. Review of the Progress Notes, dated 01/30/15 at 2:40 PM, revealed nursing staff documented they had placed Resident #10 on fifteen (15) minute checks due to increased behaviors and needing redirection from female residents. The record did not indicate what behavior the resident exhibited. The record did not indicate what interventions staff used with the resident. The record did not indicate how long the resident would remain on fifteen (15) minute supervision. The facility did not add additional progress notes pertaining to behaviors or fifteen (15) minute supervision in the shifts that followed. Review of the Psychiatric Consult/Follow-Up, dated 02/06/15, revealed the facility consulted with the Psychiatrist due to Resident #10 becoming more inappropriate with touching other residents and staff. The consult further revealed the resident had Dementia and Sexual Acting Out (SAO) behaviors. Review of the Progress Notes for Resident #10, on 03/11/15 at 5:50 AM, revealed Resident #10 was observed in the common area sucking on the breast of Resident #18. The clinical record revealed the resident was placed on 1:1 supervision until transferred to a Psychiatric Hospital. Continued review of the clinical record revealed the facility completed the Verification of Investigation form, dated 03/11/15 at 5:50 AM; however, the facility failed to complete the section for summary and outcome of investigative findings. Review of the Verification of Investigation form for Resident #18, dated 03/11/15 at 5:50 AM, revealed staff observed Resident #18 sitting on the couch raising his/her pajama top. Resident #10 was sitting on the couch next to Resident #18 and was sucking on Resident #18's breast. The resident was placed on every fifteen (15) minutes checks; however, the facility failed to complete the sections of the form titled Summary and Outcome of Investigative Findings. Interview with Certified Nursing Assistant (CNA) #5, on 04/22/15 at 2:15 PM, revealed Resident #10 had a history of [REDACTED]. The CNA stated she had to supervise the resident around other residents as he/she had a history of [REDACTED]. Interview with the Administrator, on 04/23/15 at 2:15 PM, revealed the facility did not complete an investigation of the incident of 03/11/15 where staff observed Resident #10 with his/her mouth on the breast of Resident #18. Interview with the ACU Manager, on 04/23/15 at 11:00 AM, revealed Resident #10 had a history of [REDACTED].#10 had a history of [REDACTED]. The Unit Manager stated in order to increase monitoring of the resident, the nursing staff would put Resident #10 on fifteen (15) minute checks anytime the resident exhibited SAO behaviors. The Unit Manager stated she failed to document in the clinical record what specific behaviors the resident was exhibiting on 01/30/15 that required closer supervision of the resident. The Unit Manager indicated nursing did not always document behaviors in the clinical record. Further interview with the ACU Manager, on 4/24/15 at 10:30 AM, revealed the facility staff was aware of Resident #10's inappropriate SAO behaviors prior to 03/11/15. The ACU Manager stated Resident #10 would try to touch others inappropriately and would try to walk other residents into his/her room. The resident also liked to touch staff's buttocks.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - CAMELOT	**1101 LYNDON LANE LOUISVILLE, KY 40222**

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 20) She stated Resident #10 and #18 developed an interest in each other. She stated she was the person who talked with the Intake Evaluation Coordinator from the Psychiatric Hospital and provided information related the Resident #10's behaviors. She stated after the resident's return, the information from the hospital was not placed into the resident's clinical record. She stated that information had been left in the envelope from the hospital. She had not followed up with staff to inquire why they had not put the documents into the chart. Additional interview with the ACU Manager, on 05/06/15 at 4:00 PM, revealed she talked with the Psychiatrist when he came in to let him know what was going on with the residents on the unit. The ACU Manager stated on 02/06/15 she discussed Resident #10's inappropriate behaviors with the Psychiatrist, but did not document specifically what the behaviors were in the Nursing Notes. Interview with the Director of Nursing Services (DNS), on 04/24/15 at 10:30 AM, revealed the night shift nursing staff printed out any documentation typed into the computer and placed it in the charts each night. The DNS reviewed the clinical record and stated she could not find any documented evidence the staff had provided redirection to Resident #10 prior to the incident on 03/11/15. The DNS stated she had not read the Psychiatric Hospital assessment and was unaware of the behaviors reported under the section titled Current Presenting Problems. Further interview with the DNS, on 05/06/15 at 3:15 PM, revealed the nursing staff did not document on SAO behaviors for Resident #10 on 01/30/15. The DNS stated she was aware Resident #10 had been having problems with inappropriate touching of staff, but she was unable to find documentation on SAO behaviors for Resident #10 prior to 01/30/15. Interview with the Administrator, on 05/05/15 at 8:40 AM, revealed the facility did not use behavior logs to track and monitor resident behaviors prior to the incident on 03/11/15. When a behavior happened, the Unit Managers were to document that behavior in the progress notes or SBAR (Situation, Background, Assessment, and Recommendation) as the SBAR triggered the incident report. 2. Review of Resident #29's clinical record revealed the facility admitted the resident on 04/15/15, with a [DIAGNOSES REDACTED]. Review of Resident #29's Physician order [REDACTED].#29 was ordered to have daily weights at the same time in the morning (after he/she has emptied his/her bladder/voided). If the weight goes up more than three (3) pounds in a day, the nurse was to give an additional dose of [MEDICATION NAME] ([MEDICATION NAME]) forty (40) milligrams (mg) that day. Review of Resident #29's Medication Administration Record [REDACTED]. Review of Resident #29's Vital Signs and Weight Flow Sheet revealed no weights were obtained after 04/22/15. Review of Resident #29's Progress Notes from 04/22/15 through to current, revealed no Nurses' Note verifying the Physician Orders, dated 04/22/15. Interview with RN #2, on 05/05/15 at 1:30 PM, revealed after review of Resident #29's record, there was a mistake made in the transcription of orders. RN #2 explained; when a nurse places an order in the computer system, the nurse must choose a category to place the order to ensure implementation of physician orders. The daily weight order should have been placed under the routine Medication Administration Record [REDACTED]. Instead the order was placed under a one-time only order; therefore, the facility staff did not monitor the resident's weight to ensure the resident received the diuretic according to the physician parameters. Interview with RN #3, on 05/07/15 at 9:15 AM, revealed confirmation of the process of the nurse placing a daily weight order in the computer as stated earlier by RN #2. Interview with the Assistant Director of Nursing Services (ADNS), on 05/07/15 at approximately 10:00 AM, revealed the telephone orders for the Physician Orders, dated 04/22/15, had not been placed in the clinical record originally. She obtained them signed from her office. The facility took the following actions to remove the Immediate Jeopardy on 05/28/15 by implementing the following: 1. Resident #10 was separated from the female residents and placed in sight of staff until transferred to a behavior unit for treatment on 03/11/15. Resident #10's documentation was noted in the Caretracker and Point Click Care by the Unit Manager on 04/26/15. On 03/11/15 the Charge Nurse and Certified Nursing Assistant took immediate action to ensure the safety of other residents by closely monitoring Resident #10 until transfer to the behavior treatment unit at approximately 5:20 PM. No other behaviors occurred. 2. On 04/28/15, The Nursing Home Administrator and Director of Nursing Services discussed staffing patterns in the Alzheimer's Care Unit (ACU) and Advanced Alzheimer's Care Unit (AACU) on the 11-7 shift. It was determined one Certified Nursing Assistant was added to the 11 PM-7 AM shift on the Alzheimer's Care Unit. 3. On 04/25/15 and 04/26/15 conference calls were conducted with the Administrator and Director of Nursing Services. The facility's Health Care Council guided the Administrator and the Director of Nursing Services through the location on the Policy Center and existence of behavior monitoring guidelines and log. The Area Vice-President and Field Services Clinical Director were present for both calls. On 04/27/15 the Field Services Clinical Director provided additional education to the Administrator, Director of Nursing Services, Assistant Director of Nursing, ACU/AACU Director, Director of Clinical Education, and Social Services Director on behavior management guidelines and monitoring. The Director of Nursing Services and Assistant Director of Nursing Services received education on the Behavioral Management Guideline Policy, on 03/26/15, during the quarterly clinical guideline training hosted by the Field Services Clinical Director. On 04/25/15, the Administrator received education related to the Behavior Guideline and Monitoring by the Health Care Council. The Administrator ensured the Director of Nursing Services began education and no employee would work unless they received the education. The Administrator monitored progress at least daily in the Clinical Start-Up meeting at least daily. On 04/27/15, the Files Services Clinical Director provided additional education to the Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education, ACU/AACU Director, and Social Services Director on behavioral management guidelines and behavior monitoring and charting. On 04/27/15, the Administrator consulted with the Field Services Clinical Director for investigations and incidents that may result as a reportable. There were two (2) incidents reported in April and eight (8) incidents reported in May. 4. An Ad Hoc Quality Assurance Process Improvement meeting, consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Director of Education and the Medical Director by phone was held on 04/27/15 to discuss the event of 03/11/15 and to develop a plan to prevent reoccurrence. The behavioral management guidelines and monitoring plan that the facility had implemented was discussed with the Medical Director via phone. A Quality Assurance Process Improvement Committee meeting will be held weekly x 4 weeks, then monthly thereafter. The committee will review results of the care plan and behavior log audits, behavior monitoring, and any investigations or [MEDICATION NAME]. The Behavior Monitoring Log is utilized for residents who are exhibiting behaviors. The audit identifies patterns and positive or triggering events and effectiveness of interventions. The audits will be completed weekly by the Social Worker and Director of Nursing Services and/or Assistant Director of Nursing Services. The Administrator held Quality Assurance Process Improvement meetings to review behavior care plan logs, audits, [MEDICATION NAME], and investigations on 05/04/15, 05/14/15, 05/21/15. The State Survey Agency validated the removal of Immediate Jeopardy on 06/03/15 prior to exit as follows: 1. Interview with Licensed Practical Nurse #13, on 06/01/15 at 2:55 PM, revealed until Resident #10 was transferred to a local behavioral unit he/she was kept in staff view. Review of Caretracker and Point Click Care revealed the resident was placed on 1:1 supervision until transferred on 03/11/15. Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed Resident #10 was placed on observations for the safety of ACU/AACU residents. Review of the Discharge Summary from the behavior unit on 06/02/15 revealed, Resident #10 was admitted for evaluation on 03/11/15 and discharged on [DATE] back to the facility. Interview with Licensed Practical Nurse #7, on 06/02/15 at 6:25 AM, revealed on the morning of 03/11/15 she separated the residents without difficulty and reported the incident to the House Supervisor. She stayed with the female resident and the male resident was taken to his room. Resident #10 was then monitored.

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F 0514 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 21) 2. Interview with the Director of Nursing on 06/03/15 at 8:30 AM, revealed the staffing schedule was revised to include two (2) Certified Nursing Assistants were now scheduled on the 11:00 PM to 7:00 AM shift daily for the ACU/AACU unit. She was to be notified of any scheduling difficulty and a staff member would be mandated to meet the ACU/ACCU staffing schedule. Interviews with the Licensed Practical Nurse (LPN) #7 on 06/02/15 at 9:40 AM, LPN #11, at 9:45 AM, CNA #18 at 9:46 PM, CNA #1 at 2:10 PM, validated there were now two (2) CNAs scheduled for the ACU/AACU on the 11 PM to 7 AM shift. Review of the staffing guidelines, received 06/02/15, revealed one nurse and two CNAs are scheduled for the ACU/AACU for the 11 PM-7 AM shift. Review of the daily staffing sheet from 04/28/15 to 06/02/15 revealed there were one nurse and two CNAs scheduled for the units on the 11 PM-7 AM shift except for 05/03/15. 3. Interview with the Area Vice-President on 06/02/15 at 3:35 PM, revealed she was present at the 04/25/15, the 04/26/15, and the 04/27/15 conference calls for the education of the Behavioral Guidelines and Monitoring log and could validate the Administrator and the Director of Nursing Services was in attendance. Interview with the Field Service Clinical Director on 06/03/15 at 1:35 PM, validated she was the moderator for the education on the Behavior Policy and Guideline Log, on the conference calls, and she attended the Ad Hoc and all Quality Assurance Process Improvement meetings. In addition, she revealed education of the Behavioral Management Guideline Policy was provided to the Director of Nursing Services and Assistant Director of Nursing Services during the quarterly clinical training on 03/26/15. Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the Assistant Director of Nursing Services, on 06/03/15 at 3:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the ACU/ACCU Manager/Director on 06/03/15 at 1:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Telephone interview with the former Administrator, on 05/22/15 at 4:35 PM, revealed he had received training on the Behavior Policy and Log on 04/25/15 from the Field Service Director. In addition, he stated the Director of Nursing Services was assigned to begin education and no employee was allowed to work until they were trained. Record review of the Human Resource employee roster on 06/03/15 revealed, all staff were trained except for: two (2) staff not on schedule, two (2) new hired that began their employment 06/01/15 and were in orientation. Training for behaviors and the behavior log was now part of orientation. Three (3) staff were on Family Medical Leave and one (1) PRN staff had not worked. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed training on the Behavior Policy and log was completed on 04/27/15. Staff that were off received training before their shift. Staff not trained were notified they would not be scheduled to work, until they were trained. In the morning meetings the behavior logs were reviewed. To date one resident on the ACU unit had to be placed on a 1:1 for behaviors. Any resident on [MEDICAL CONDITION] medications or that exhibited behaviors was placed on the behavior log. They are placed in the medication administration binder. Review of the quarterly Clinical Guideline training sign in sheet, dated 03/26/15, revealed the Director of Nursing Services and the Assistant Director of Nursing were trained on the policies by the Field Services Clinical Director. Interview with the Field Services Clinical Director on 06/03/15 at 2:35 PM, revealed the Administrator reports all incidents and [MEDICATION NAME] to her. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed she reports to the Field Services Clinical Director. Review of reportable incidents, on 06/03/15, revealed from 04/23/15 to 05/31/15 the Administrator reported twelve (12) incidents to the Field Services Clinical Director and State Agencies. 4. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed Quality Assurance Improvement Process meetings would be held weekly for four (4) weeks, bi-weekly for four (4) weeks, and then monthly thereafter. At the meetings care plans, behavior log audits, behavior monitoring, investigations, and [MEDICATION NAME] would be discussed. Causative patterns or trigger events and the effectiveness of interventions would be discussed. The behavior log audits would be completed weekly and reported at the meeting by the social worker. Record review on 06/03/15, revealed the Administrator, Director of Nursing Services, Assistant Director of Nursing, Social Services, Director of Education, and the Medical Director were present at an Ad Hoc meeting held 04/27/15 and Quality Assurance Improvement Process meetings on 04/29/15, 05/04/15, 05/14/15, and on 05/21/15.
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to have an effective Quality Assurance (QA) Committee to ensure ongoing compliance of corrected deficiencies. The facility was cited for not maintaining correction of identified quality deficiencies with their infection control program for three (3) consecutive Recertification Surveys. Review of the Plan of Correction submitted for the 2014 survey revealed the facility was to monitor noncompliance through the QA committee for two (2) quarterly meetings. If there were any issues with the lack of compliance, staff would be retrained. Annually, nursing staff would have infection control proficiency checks by the Director of Clinical Education (DCE). Observation during this Recertification/Extended Survey (April 21-May 7, 2015) revealed the facility failed to consistently implement plans of actions to correct identified deficiencies and remain in compliance with state and federal regulations. In addition, the facility failed to identify quality deficiencies related to behaviors and failed to develop and implement plans of action to correct those deficiencies. Observations revealed deficient practice was found for issues regarding infection control. The facility failed to maintain compliance in areas that would prevent cross-contamination during a wound dressing, isolation precautions, catheterization and hand hygiene. Refer to F441. The facility identified Residents #10 and #18 with sexually acting out (SAO) behaviors. On 03/11/15 at 5:50 AM, the facility staff observed Resident #10 sitting on a couch with his/her mouth on Resident #18's breast. The facility identified Resident #10 had a history of [REDACTED]. The facility failed to investigate the incident and failed to conduct an Quality Assurance meeting to discuss these behaviors. Refer to F323 The Quality Assurance Committee's failure to sustain compliance of corrected deficiencies has caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 03/11/15. An Acceptable Allegation of Compliance (AOC) was received on 05/28/15 which alleged removal of the Immediate Jeopardy on 05/28/15. The State Survey Agency determined the Immediate Jeopardy was removed on 05/28/15 prior to exit of the survey on 06/03/15. The Scope and Severity was lowered to a D while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review on 04/23/15 at 2:30 PM of the QA Signature Sheets, revealed the facility conducted QA meetings at least quarterly with the required members. WHAT DOES THE QA POLICY SAY ?? Review of the facility's policy for [MEDICAL CONDITION] (MDRO), dated August 2014, revealed the facility would take appropriate precautions when caring for residents with MDRO. The use of Contact Precautions would be determined on a case by case basis. Residents with a risk for transmission include residents with total dependence for activities of daily living may require contact precautions. A resident with a MDRO may need to be separated from a roommate who has a gastronomy feeding tube. Review of the clinical record for Resident #1 revealed the facility readmitted the resident on 04/14/15 status [REDACTED]. Interview with the Director of Nursing Services (DNS), on 04/23/15 at 11:25 AM, revealed contact precautions were not necessary for residents with multiple drug resistant organisms (MDRO) infections if the infection was contained. The DNS stated Resident #1's roommate had a gastrostomy tube, and that was missed, and residents with those types of tubes should not be in rooms with residents having MDRO infections. She stated she was aware that Resident #1 [MEDICAL CONDITION] in the

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 22) surgical wound but missed having staff place the resident in contact precautions. Interview with the Director of Continued Education (DCE)/Infection Control Nurse, on 04/24/15 at 7:54 AM, revealed she was unaware Resident #1 [MEDICAL CONDITION] in the wound. That fact had not been communicated to her because she did not attend the morning clinical meetings. She said she would review Physician Orders, SBAR reports, and lab results and once a month obtain a cumulative report to help track and trend infections. She stated the corporation required specific monthly in-service education, but they pick the topic, not her. She stated nurses must complete annual competency training with check offs required. However, the last check off on skills with return demonstration was in April 2014. She indicated the corporation did all the scheduling of training without her input. A training on infection control was scheduled for July 2015. Observation of wound care treatment for [REDACTED].#1, on 4/22/15 at 3:05 PM, revealed the nurse did not create a clean field for the treatment supplies used for the wound care and dressing change. The wound on the bottom of the foot revealed a small amount of clear drainage. Treatment Nurse/LPN #1 measured the wounds, but he did not remove his gloves and wash his hands before leaving the room to retrieve cotton applicators from the treatment cart. Treatment Nurse/LPN #1 left the room and returned; however, he did not remove his gloves and wash his hands prior to cleansing and dressing the wounds. Interview with the Director of Nursing (DNS), on 4/23/15 at 11:10 AM, revealed she regularly monitored wounds and had observed dressing changes done by Treatment Nurse/LPN #1. She stated she had observed the nurse not performing hand hygiene between dirty and clean and had to remind him to changes his gloves. She stated when concerns were identified, education was provided on the spot but was not documented. She stated the bedside tables should be cleaned before supplies are laid on them. She stated there was not an audit tool in place to monitor for infection control during dressing changes. 3. Observation, on 04/23/15 at 11:25 AM, revealed LPN #5 assisted Resident #7 to the bathroom to urinate prior to a straight catheterization. The resident was assisted to bed, and it was noted the resident's brief was soiled with a small amount of feces. The nurse disposed of the soiled brief, but did not provide incontinent care; she washed her hands and applied clean gloves. The nurse opened the sterile catheterization kit and placed the container on the resident's bedside table. The table had not been cleaned and no sterile field had been created. The nurse opened the package and applied the sterile gloves. She cleaned the urinary meatus with a [MEDICATION NAME] swab, touching the resident's inner thigh. She removed the swab and threw it onto the paper container the sterile gloves came in. The other clean [MEDICATION NAME] swabs were placed on the paper too. The nurse took another swab and cleansed the urinary meatus outside first. The nurse placed the used swab onto the paper with the other clean swab. The nurse could not obtain a urine return and after several attempts had to stop. She removed the catheter and placed a clean brief on the resident without incontinent care. Interview with LPN #5, on 04/23/15 at 11:50 PM, revealed she normally did not provide a sterile field and would place supplies onto the sterile gloves package. She stated she had not cleaned the resident after removal of the soiled brief as it was such a small amount of feces and she had placed the sterile pad under the resident's buttocks. and failed to drape the resident before the procedure. She indicated she had been taught on the procedure in nursing school, but did not think that procedure was included in the annual competency skills at the nursing facility. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 01/20/14 with the [DIAGNOSES REDACTED]. The resident was under the care of an Urologist that ordered for the resident to be straight catheterized (in and out) four times a day. The clinical record revealed the resident experienced several chronic Urinary Tract Infections [MEDICAL CONDITION] in January and February 2015 and was recently treated with antibiotic medication for a UTI on 04/09/15. 4. On 03/11/15 at 5:50 AM, the facility staff observed Resident #10 sitting on a couch next to Resident #18 with his/her mouth on the resident's right breast. The facility placed Resident #10 on 1:1 supervision and requested inpatient psychiatric hospitalization . Review of the intake assessment conducted by the hospital, 03/11/15 at 1:00 PM, revealed the resident was exhibiting sexually acting out (SAO) behaviors. The hospital Intake Coordinator documented the SAO behaviors presented a threat of harm to other residents. The facility identified the resident had a history of [REDACTED]. The resident required hospitalized from [DATE] to 03/24/15. Refer to 323. Interview with the Administrator, on 04/22/15 at 4:00 PM, revealed he was informed of the incident between Residents #10 and #18 on 03/11/15. He stated he met with the DNS and they decided it was not a reportable incident, it was just behaviors. He stated no investigation was conducted regarding the residents behaviors because Resident #10 was placed on 1:1 supervision and then transferred to a Psychiatric Hospital for treatment. The Administrator stated Resident #18's family was aware of the incident and had no concerns. He further stated neither he nor the DNS looked at staffing and he was unaware the residents were left unsupervised because of staffing issues. The Administrator stated he did not discuss the Sexual Behaviors during the monthly QA meetings with the facility staff and had not discussed this with the Medical Director. He stated behaviors had not been a routine topic discussed at the quarterly QA meetings, just discussion of [MEDICAL CONDITION] medication use. Another interview with the Administrator, during the QA review task, on 04/23/15 at 2:30 PM, revealed infection control was included for discussion during the quarterly QA meetings. The Administrator stated the Infection Control Nurse brought the lab reports on infections and antibiotic use from pharmacy to discuss at the QA meetings. In addition, he stated the daily clinical meetings should discuss what was happening with the residents. He only attended a portion of the clinical meetings related to the discussion of falls. He stated the DNS has oversight of the clinical practice of nursing that would include skin reports, hand hygiene, precautions, and infection control. He had not been informed of any problems noted with non-compliance with infection control practices. He stated the facility had developed a plan of correction to correct the deficient practice cited under the infection control tag last year; however, they had not ensured all aspects of the tag was monitored for compliance. The facility took the following actions to remove the Immediate Jeopardy on 05/28/15 by implementing the following: 1. Resident #10 was separated from the female residents and placed in sight of staff until transferred to a behavior unit for treatment on 03/11/15. Resident #10's documentation was noted in the Caretracker and Point Click Care by the Unit Manager on 04/26/15. On 03/11/15 the Charge Nurse and Certified Nursing Assistant took immediate action to ensure the safety of other residents by closely monitoring Resident #10 until transfer to the behavior treatment unit at approximately 5:20 PM. No other behaviors occurred. 2. On 04/28/15, The Nursing Home Administrator and Director of Nursing Services discussed staffing patterns in the Alzheimer's Care Unit (ACU) and Advanced Alzheimer's Care Unit (AACU) on the 11-7 shift. It was determined one Certified Nursing Assistant was added to the 11 PM-7 AM shift on the Alzheimer's Care Unit. 3. On 04/25/15 and 04/26/15 conference calls were conducted with the Administrator and Director of Nursing Services. The facility's Health Care Council guided the Administrator and the Director of Nursing Services through the location on the Policy Center and existence of behavior monitoring guidelines and log. The Area Vice-President and Field Services Clinical Director were present for both calls. On 04/27/15 the Field Services Clinical Director provided additional education to the Administrator, Director of Nursing Services, Assistant Director of Nursing, ACU/AACU Director, Director of Clinical Education, and Social Services Director on behavior management guidelines and monitoring. The Director of Nursing Services and Assistant Director of Nursing Services received education on the Behavioral Management Guideline Policy, on 03/26/15, during the quarterly clinical guideline training hosted by the Field Services Clinical Director. On 04/25/15, the Administrator received education related to the Behavior Guideline and Monitoring by the Health Care Council. The Administrator ensured the Director of Nursing Services began education and no employee would work unless they received the education. The Administrator monitored progress at least daily in the Clinical Start-Up meeting at least daily. On 04/27/15, the Files Services Clinical Director provided additional education to the Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education, ACU/AACU Director, and Social Services Director on behavioral management guidelines and behavior monitoring and charting. On 04/27/15, the Administrator consulted with the Field Services Clinical Director for investigations and incidents that may result as a reportable. There were two (2) incidents reported in April and eight (8) incidents reported in May. 4. An Ad Hoc Quality Assurance Process Improvement meeting, consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Director of Education and the Medical Director by phone was held on

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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 -** Few	(continued... from page 23) 04/27/15 to discuss the event of 03/11/15 and to develop a plan to prevent reoccurrence. The behavioral management guidelines and monitoring plan that the facility had implemented was discussed with the Medical Director via phone. A Quality Assurance Process Improvement Committee meeting will be held weekly x 4 weeks, then monthly thereafter. The committee will review results of the care plan and behavior log audits, behavior monitoring, and any investigations or [MEDICATION NAME]. The Behavior Monitoring Log is utilized for residents who are exhibiting behaviors. The audit identifies patterns and positive or triggering events and effectiveness of interventions. The audits will be completed weekly by the Social Worker and Director of Nursing Services and/or Assistant Director of Nursing Services. The Administrator held Quality Assurance Process Improvement meetings to review behavior care plan logs, audits, [MEDICATION NAME], and investigations on 05/04/15, 05/14/15, 05/21/15. The State Survey Agency validated the removal of Immediate Jeopardy on 06/03/15 prior to exit as follows: 1. Interview with Licensed Practical Nurse #13, on 06/01/15 at 2:55 PM, revealed until Resident #10 was transferred to a local behavioral unit he/she was kept in staff view. Review of Caretracker and Point Click Care revealed the resident was placed on 1:1 supervision until transferred on 03/11/15. Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed Resident #10 was placed on observations for the safety of ACU/AACU residents. Review of the Discharge Summary from the behavior unit on 06/02/15 revealed, Resident #10 was admitted for evaluation on 03/11/15 and discharged on [DATE] back to the facility. Interview with Licensed Practical Nurse #7, on 06/02/15 at 6:25 AM, revealed on the morning of 03/11/15 she separated the residents without difficulty and reported the incident to the House Supervisor. She stayed with the female resident and the male resident was taken to his room. Resident #10 was then monitored. 2. Interview with the Director of Nursing on 06/03/15 at 8:30 AM, revealed the staffing schedule was revised to include two (2) Certified Nursing Assistants were now scheduled on the 11:00 PM to 7:00 AM shift daily for the ACU/AACU unit. She was to be notified of any scheduling difficulty and a staff member would be mandated to meet the ACU/ACCU staffing schedule. Interviews with the Licensed Practical Nurse (LPN) #7 on 06/02/15 at 9:40 AM, LPN #11, at 9:45 AM, CNA #18 at 9:46 PM, CNA #1 at 2:10 PM, validated there were now two (2) CNAs scheduled for the ACU/AACU on the 11 PM to 7 AM shift. Review of the staffing guidelines, received 06/02/15, revealed one nurse and two CNAs are scheduled for the ACU/AACU for the 11 PM-7 AM shift. Review of the daily staffing sheet from 04/28/15 to 06/02/15 revealed there were one nurse and two CNAs scheduled for the units on the 11 PM-7 AM shift except for 05/03/15. 3. Interview with the Area Vice-President on 06/02/15 at 3:35 PM, revealed she was present at the 04/25/15, the 04/26/15, and the 04/27/15 conference calls for the education of the Behavioral Guidelines and Monitoring log and could validate the Administrator and the Director of Nursing Services was in attendance. Interview with the Field Service Clinical Director on 06/03/15 at 1:35 PM, validated she was the moderator for the education on the Behavior Policy and Guideline Log, on the conference calls, and she attended the Ad Hoc and all Quality Assurance Process Improvement meetings. In addition, she revealed education of the Behavioral Management Guideline Policy was provided to the Director of Nursing Services and Assistant Director of Nursing Services during the quarterly clinical training on 03/26/15. Interview with the Director of Nursing Services, on 06/02/15 at 10:10 AM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the Assistant Director of Nursing Services, on 06/03/15 at 3:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Interview with the ACU/ACCU Manager/Director on 06/03/15 at 1:53 PM, revealed she was present for the education conference calls, attended the Ad Hoc and all Quality Assurance Process Improvement meetings. Telephone interview with the former Administrator, on 05/22/15 at 4:35 PM, revealed he had received training on the Behavior Policy and Log on 04/25/15 from the Field Service Director. In addition, he stated the Director of Nursing Services was assigned to begin education and no employee was allowed to work until they were trained. Record review of the Human Resource employee roster on 06/03/15 revealed, all staff were trained except for: two (2) staff not on schedule, two (2) new hired that began their employment 06/01/15 and were in orientation. Training for behaviors and the behavior log was now part of orientation. Three (3) staff were on Family Medical Leave and one (1) PRN staff had not worked. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed training on the Behavior Policy and log was completed on 04/27/15. Staff that were off received training before their shift. Staff not trained were notified they would not be scheduled to work, until they were trained. In the morning meetings the behavior logs were reviewed. To date one resident on the ACU unit had to be placed on a 1:1 for behaviors. Any resident on [MEDICAL CONDITION] medications or that exhibited behaviors was placed on the behavior log. They are placed in the medication administration binder. Review of the quarterly Clinical Guideline training sign in sheet, dated 03/26/15, revealed the Director of Nursing Services and the Assistant Director of Nursing were trained on the policies by the Field Services Clinical Director. Interview with the Field Services Clinical Director on 06/03/15 at 2:35 PM, revealed the Administrator reports all incidents and [MEDICATION NAME] to her. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed she reports to the Field Services Clinical Director. Review of reportable incidents, on 06/03/15, revealed from 04/23/15 to 05/31/15 the Administrator reported twelve (12) incidents to the Field Services Clinical Director and State Agencies. 4. Interview with the new Administrator, on 06/03/15 at 2:43 PM, revealed Quality Assurance Improvement Process meetings would be held weekly for four (4) weeks, bi-weekly for four (4) weeks, and then monthly thereafter. At the meetings care plans, behavior log audits, behavior monitoring, investigations, and [MEDICATION NAME] would be discussed. Causative patterns or trigger events and the effectiveness of interventions would be discussed. The behavior log audits would be completed weekly and reported at the meeting by the social worker. Record review on 06/03/15, revealed the Administrator, Director of Nursing Services, Assistant Director of Nursing, Social Services, Director of Education, and the Medical Director were present at an Ad Hoc meeting held 04/27/15 and Quality Assurance Improvement Process meetings on 04/29/15, 05/04/15, 05/14/15, and on 05/21/15.