

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

PRINTED: 06/05/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185093 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/02/2014 |
| NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW | | | STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141 | | |
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| F 000 | <p>INITIAL COMMENTS</p> <p>An Abbreviated/Partial Extended Survey investigating complaint #KY21580 was conducted on 04/14/14 through 05/02/14 to determine the facility's compliance with Federal requirements. Complaint #KY21580 was substantiated with deficiencies cited.</p> <p>Abbreviated survey (KY #21645) was conducted in conjunction with the extended survey on 05/01-02/14. KY #21645 was unsubstantiated with no deficiencies cited.</p> <p>Immediate Jeopardy was identified in the areas of 483.13 Resident Behavior and Facility Practice; F-223, F-225 and F-226; 483.20, Resident Assessment; F-280; and, 483.75 Administration; F-490 at a Scope and Severity of a "J". Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practice. Immediate Jeopardy was identified on 04/22/14 and determined to exist on 01/15/14. The facility was notified of the Immediate Jeopardy on 04/22/14.</p> <p>On 03/19/14, the facility was made aware of an allegation of mistreatment of Resident #1 by staff, when the Office of the Attorney General (OAG) and the Department for Community Based Services (DCBS) conducted an investigation at the facility. Video recordings from a "Nanny Cam" that had been placed in Resident #1's and Resident #2's shared room revealed two (2) CNAs displayed inappropriate behaviors towards Resident #1 that included taunting, making inappropriate sexual gestures in front of the resident, and threatening behaviors of pointing a finger directly in the resident's face on multiple</p> | F 000 | <p>This Allegation of Compliance is submitted as required under State and Federal Law. the Center's submission of this Allegation of Compliance does not constitute an admission on the part of the Center that the findings constitute a deficiency, or the scope and severity determination is correct.</p>  | 05/03/14 | |

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

TITLE

(X6) DATE

[Handwritten Signature]

Admin

6/9/14

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

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| F 000 | Continued From page 1 dates. Staff, who observed the other staff mistreating the resident, failed to report the incidents to the Administrator. Additionally, the facility failed to assess residents who could not speak for themselves for signs and symptoms of abuse/mistreatment after they were made aware of the investigation by the Office of the Attorney General and the Department of Community Based Services on 03/19/14. An acceptable Allegation of Compliance (AoC) was received on 04/25/14, alleging the removal of Immediate Jeopardy on 04/25/14. The State Survey Agency validated, on 05/01/14-05/02/14, that the Immediate Jeopardy was removed on 04/25/14, as alleged. The Scope and Severity was lowered to a "D" at 483.13, Resident Behavior and Facility Practice at F-223, F-225 and F-226; 483.20, Resident Assessment; at F-280; and 483.75 Administration, at F-490, while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes. | F 000 | | | |
| F 223 SS=J | 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. | F 223 | NHC HealthCare, Glasgow ensures that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, or involuntary seclusion. March 19, 2014, DCBS Social Worker came to the Center and stated that she had allegations or rough handling, degrading comments, theft of personal property and medication error involving two residents. DCBS requested that three employees be suspended but stated that she could not tell us why at this time. The Administrator notified the employees of their suspension, contacted both local police and OIG, 03/19/14, to inform them of the | 05/03/14 | |

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| F 223 | <p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of video recordings, interviews, record reviews and review of the facility's "Abuse/Neglect and Misappropriation of Resident Property" policy and procedure, it was determined the facility failed to ensure one (1) of five (5) sampled residents (Resident #1), was free from abuse. The facility failed to have an effective system in place to ensure residents were free from abusive treatment by staff; and, failed to ensure staff reported the observed mistreatment of residents immediately.</p> <p>The facility's Certified Nurse Aides (CNA) were video recorded by a "Nanny Cam" placed in Resident #1's and #2's shared room by a family member. The video recordings revealed the CNAs, who were providing care to Resident #1, were displaying inappropriate behaviors. The CNAs were video recorded on different dates, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing their finger at the resident in a threatening manner just inches from his/her face after care had been provided.</p> <p>The facility's failure to ensure residents were free from abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist on 01/15/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property", dated</p> | F 223 | <p>allegations and ongoing investigation. During the course of the investigation, DCBS social worker notified the administrator to suspend an additional LPN and CNA. This was done immediately. During the investigation the LPN was cleared and returned to work. One CNA was terminated after admitting to taking 55 dollars from resident Number 2. An additional CNA was also terminated. Two CNAs remain suspended awaiting the review of the video. Once the administrator is allowed to review the video, further action will be taken as deemed appropriate.</p> <p>03/19/14, the physician and family for each resident were contacted by the Director of Nursing and informed of the allegation and investigation. The physician came to the center the next day, 03/20/14, and saw each resident. The physician gave no new orders.</p> <p>Overseen by the Regional Nurse, on 04/21/14, RN Units Manager and RN Supervisor conducted resident physical assessments for injuries of unknown origin on both resident #1 and resident #2, no injuries of unknown origin were found.</p> <p>The Regional Nurse, Regional Social Service Director and RN Unit Manager reviewed and updated as needed resident #1 and resident #2 care plans with focus on ensuring that interventions related to specific resident behaviors were care planned as needed. This review was completed on 4/23/14.</p> <p>How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken Beginning 03/19/14, interviews with all employees were conducted by RNs/Unit Managers, Nurse Supervisors, and Department Heads. As part of their in-service training on the Center's Abuse/Neglect and Misappropriation of Resident Property policy, each employee was asked if they had knowledge of abuse occurring in the center. No employee said that they were aware of abuse</p> | | |

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| F 223 | <p>Continued From page 3</p> <p>09/24/09, revealed the policy and procedures shall be in place to prevent resident abuse. The policy defined the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish as abuse. The policy listed controlling behavior through corporal punishment as physical abuse. Mental abuse was listed as including, but not limited to, humiliation, harassment and threats of punishment or deprivation.</p> <p>Record review revealed the facility admitted Resident #1 on 08/13/09 with diagnoses which included Alzheimer's Disease, Dysphagia and Dementia with Behavior Disturbance. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/20/14, revealed the facility staff's assessment of Resident #1's cognitive status was severely impaired and the resident required extensive assistance with transfers, hygiene and bathing and was incontinent at times of bowel and bladder. In addition, the resident had behaviors of being resistive to care at times. An attempt on 04/15/14 at 9:00 AM to interview Resident #1 was unsuccessful due to the Resident's severe cognitive impairment.</p> <p>Review of the video recording, on 04/14/14, revealed the following:</p> <p>1. On 01/10/14 at 10:02 PM, two (2) CNAs provided care for Resident#1 (one on the side of the bed by the door and the other one was on the side by the window). Resident #1 was resistive and attempting to pinch the CNA nearest the window of the room. The CNA, not smiling, appeared to be saying something to Resident #1 and then pointed her finger in Resident #1's face</p> | F 223 | <p>occurring in the Center. Those employees that are unavailable/on leave will be interviewed prior to their next shift worked. This was completed on 03/20/14</p> <p>Overseen by the Regional Nurse, on 4/21/14, RNs/ Unit Managers and Nurse Supervisors conducted resident physical assessments for injuries of unknown origin on all residents in the center, no injuries of unknown origin were found. Beginning 04/22/14, overseen by the Regional Nurse, RNs/ Unit Managers and Nurse Supervisors reviewed and updated as needed, all resident's care plans with focus on ensuring that interventions related to residents behaviors were care planned as needed. This review was completed on 04/23/14.</p> <p>The Measures we have put in Place and Systematic Changes We have Made to Ensure That The Practice Does Not Recur.</p> <p>Overseen by the Administrator, in-service training was conducted by the Department Heads, RNs/ Unit Managers and Nurse Supervisors, on the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property," began on 03/19/14 for all employees. In-service training emphasized the employees understanding of the types of abuse, reporting abuse, their role in providing an environment free of abuse, immediately protecting the patient when abuse is witnessed and the signs of employee burn out. Those employees that are unavailable/on leave will be interviewed and in-serviced prior to their next shift worked. This was completed on 03/20/14. 04/22/14, the Regional Nurse met with and in-serviced the Administrator and Director of Nursing regarding the Center's "Policy Regarding Abuse/ Neglect and Misappropriation of Resident Property." They reviewed and updated the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property." The Center's Policy was updated to include a specific assessment of non-interviewable patients for potential abuse during investigations. The Regional Nurse and Administrator contacted the Medical</p> | | |

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| F 223 | <p>Continued From page 4 in a threatening manner</p> <p>2. On 01/11/14 at 4:10 AM, two (2) CNAs entered the resident's room, closed the hall door and while standing in view of Resident #1 at the foot of Resident #1's bed, one of the CNAs bent over and bit or kissed the buttocks of the other CNA. The CNAs then provided care to Resident #1.</p> <p>3. On 01/15/14 at 10:56 PM, two (2) CNAs provided care to Resident #1 and when the resident was resistive, his/her hands were restrained on the resident's chest and one of the CNAs (nearest the window) moved to the head of the bed leaning forward into the resident's face in a threatening manner.</p> <p>4. On 01/17/14 at 4:00 AM, two (2) CNAs provided care to Resident #1 and one (1) of the CNAs (nearest the door) picked up a banana off the resident's bed side table and made an inappropriate sexual gesture like she was going to stick the banana between the resident's legs.</p> <p>5. On 02/03/14 at 1:18 AM, two (2) CNAs provided care to Resident #1. The resident was kicking out and being resistive. One of the CNAs was restraining Resident #1's hands at the wrist. The CNAs finished care and moved to exit from the room when one of the CNAs (nearest the door) turned and returned to the head of the resident's bed pointing a finger at the resident's face and then reached toward the resident's face, leaving her hands in the resident's face for several seconds. The video did not reveal where the CNA's hands went.</p> <p>6. On 02/03/14 at 4:21 AM, two (2) CNAs</p> | F 223 | <p>Director and informed him of the policy revision.</p> <p>Following this revision, the Regional Nurse in-serviced Department Heads regarding the revised "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property," on 04/22/14. Then following this in-service, beginning on 04/22/14, overseen by the Regional Nurse, Department Heads conducted in-service training with all employees regarding the center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property," specifically reviewing the revision in the center's policy regarding assessment of non-interviewable patients for potential abuse during investigations. Those employees that are on leave/unavailable will be in-serviced prior to their next shift. This was completed on 04/23/14. Overseen by the Director of Nursing, in-service training for licensed nurses was conducted by the DON, RNs/Unit Managers and Nurse Supervisors, on the Nurse's role in administration of Medications and Treatments, began on 03/21/14. In-service training emphasized the nurses understanding in following physician orders, safe administration and documentation. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 03/21/14. Overseen by the Regional Director of Social Services in-service training was conducted by the DON, RNs/ Unit Managers and Nurse Supervisors, with Licensed Nurses and CNAs on "Recognizing and Managing Alzheimer's Type Dementia," began on 03/20/14. In-service training emphasized the nurse's and CNA's understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 03/21/14. Overseen by the Regional Director of Social Services, in-service training was conducted by the DON, RNs/ Unit Managers, and Nurse Supervisors, with Licensed Nurses and CNAs on "Caregiver Stress and Burnout, began on 03/22/14.</p> | | |

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| F 223 | <p>Continued From page 5</p> <p>entered the resident's room and stood over Resident #1. One CNA (nearest the door) showed the other CNA (nearest the window) her left breast and the other CNA (nearest the window) performed a breast exam on herself in front of Resident #1. Both CNAs then stood over Resident #1 and talked on their cell phones. The CNAs left the room without providing any care for Resident #1.</p> <p>7. On 03/12/14 at 9:00 PM, two (2) CNAs entered the resident's room. Resident #1 repeatedly pushed the cover back from his/her face and one (1) of the CNAs (nearest the window) flipped the cover back over the resident's face five (5) different times. The CNA pointed a finger near the resident's face and then made a taunting gesture of holding her hands by her ears while waving her fingers.</p> <p>Interview with a family member of Resident #1, on 04/14/14 at 9:45 AM, revealed she had placed a "Nanny Cam" in the room on 01/10/14 to monitor Resident #1's care after facial bruising was identified to Resident #1's face the first week of January. She further stated the facility had determined the bruising was self-inflicted; however, the family member was certain the bruising was not self-inflicted.</p> <p>Interview with the DCBS Representative, on 04/17/14 at 8:30 AM, revealed she had been to the facility on 03/19/14 in conjunction with an investigator from the OAG office as the family had taken the video recordings to the OAG. She stated interviews were conducted and schedules and assignment sheets were used to identify which CNAs were providing care on the days in question. The CNAs were identified as CNA #1,</p> | F 223 | <p>In-service training emphasized the employees undersatnding of common signs and symptoms of caregiver burnout and Dealing with Caregiver Stress and Burnout Prevention Tips. Those employees that are unavailable/ on leave will be interviewed and in-service prior to next shift worked. This was completed on 03/24/14.</p> <p>Beginning 04/22/14, the Regional Nurse and Regional Director of Social Service provided Care Planning in-service training for the Director of Nursing, RN/Unit Managers and Clinical Social Workers involved in overseeing the Center's care plan process. The in-service training covered ensuring that inventions related to resident behaviors are care planned as needed. Those employees that are unavailable/on leave will be in-service prior to their next shift worked. This was completed on 04/23/14.</p> <p>The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur On April 22,2014, The Regional Nurse reviewed with the Director of Nursing the Quality Assurance Monitors that began the week of March 23,2014. Monitors reviewed include; 20 random employees per week for 6 weeks will be interview for their understanding of the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property." Following the Regional Nurse's review, this monitor will be extended for and additional 4 weeks following the 04/22/14 revision of the policy. 10 random Licensed Nurses per week for 4 weeks will be interviewed for their understanding of their role on adminstration of Medications and Treatments. 20 Medication Records per week for 4 weeks will be reviewed for compliance with the Center's policy regarding medication administration. 15 random CNAs and 5 random Licensed Nurses per week for 6 weeks will be interviewed for their understanding of recognizing care of residents with dementia with emphasis on their understanding of</p> | |

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| F 223 | <p>Continued From page 6 CNA #2 and CNA #3.</p> <p>Attempts to contact CNA #1 and CNA #3 on 04/16/14 were unsuccessful because their telephone numbers were disconnected.</p> <p>An interview by phone with CNA #2 was conducted on 04/21/14 at 12:15 PM. CNA #2 revealed she had been suspended and questioned about rough handling of Resident #1. CNA #2 stated she had told the Administrator she did not do it (treat the resident roughly).</p> <p>Interview with the Administrator and Director of Nursing (DON), on 04/14/14 at 3:15 PM, revealed the facility was made aware of the allegation on 03/19/14 when the OAG Investigator and a DCBS Representative were at the facility. The Administrator stated he was told by the DCBS Representative to suspend three (3) people that included CNA #1, CNA #2 and CNA #3. The Administrator stated he was not informed of any details of the allegation at the time and was told by DCBS the facility could not conduct an investigation. The Administrator stated on 04/08/14, the OAG Investigator revealed eight (8) to ten (10) video clips to the Administrator. The Administrator stated the OAG Investigator stated the CNAs' behavior was unprofessional and poor technique but did not rise to criminal. The Administrator felt one of the videos could have been "rough handling" and that CNA #1 was terminated. He further stated the facility reported her to the Nurse Aide Abuse Registry. Further interview revealed the Administrator and DON stated there had not been any allegations of mistreatment of Resident #1 until 03/19/14 when the OAG and DCBS came into the building to investigate.</p> | F 223 | <p>interacting with and caring for residents with dementia.</p> <p>15 random CNAs and 5 random Licensed Nurses per week for 6 weeks will be interviewed for their understanding of recognizing Care Giver Burnout. Additionally following the Regional Nurse's review, Overseen by the Regional Nurse and Director of Nursing, two Quality Assurance Monitor, which include care plans of residents with behaviors and non-interviewable residents physical assessments, will begin the week of April 23, 2014.</p> <p>One monitor in which 10 random care plans of residents with behaviors will be reviewed weekly for 6 weeks by RN/Unit Managers and Nurse Supervisors to monitor for appropriate interventions related to their specific behavior care plan.</p> <p>A second Quality Assurance Monitor will be conducted in which residents' physical assessments will be conducted by RN/Unit Managers, and Nurse Supervisors on 10 random non-interviewable residents weekly for 6 weeks to ensure appropriate documentation.</p> <p>The Regional Nurse will review all Quality Assurance monitors with Director of Nursing each month. All Quality Assurance monitors will be reported to the Center's Quality Assurance committee consisting of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, and HIM Director monthly. In-service training and Quality Assurance monitors will continue as directed by the Quality Assurance Committee and the Regional Nurse.</p> | | |

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| F 223 | <p>Continued From page 7</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 03/19/14, the facility suspended and then terminated CNAs #1, #2, #3 and #4. CNA #1 was reported to the Nurse Aide Abuse Registry by the Administrator.</p> <p>On 04/21/14, the Regional Nurse provided oversight as Unit Managers assisted by other licensed staff (total of ten) and the RN Supervisor conducted physical assessments for signs/symptoms of possible abuse on all residents including Resident #1; no injuries were found. The care plans for Resident #1 were reviewed and updated with focus on interventions specific to the resident's behaviors.</p> <p>The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy.</p> <p>On 04/22/14, the Regional Nurse in-serviced the Administrator and Director of Nursing regarding the facility's abuse/neglect policy. Together they reviewed and revised the policy to include specific assessment of non-interviewable residents for potential abuse during investigations. The Medical Director was informed of the policy revision. Beginning 04/22/14, all facility employees were inserviced regarding the revision in the policy and employees on leave or unavailable would have the inservice prior to working their next shift; this was completed on 04/23/14.</p> <p>Inservice training was provided to licensed staff by the DON, RNs and Unit Managers and Nurse</p> | F 223 | | | |

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| F 223 | <p>Continued From page 8</p> <p>Supervisors on recognizing and managing Alzheimer type dementia and emphasized the nurses' and CNAs' understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. This was initiated on 03/20/14 and completed on 03/21/14.</p> <p>Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy including the types of abuse and interviewing residents. An additional four (4) weeks of monitoring was added following the 04/22/14 revision that included the assessment of non-interviewable residents for potential signs and symptoms of abuse. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Ten (10) random care plans will be reviewed weekly for six (6) weeks by the RN/Unit Managers for appropriate interventions related to specific behavior care plan. The monitors will be completed 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee.</p> <p>The State Survey Agency validated the Corrective action taken by the facility as follows:</p> <p>Record review for Resident #1 and Resident #2, on 05/01/14, revealed Resident #1 and Resident #2 were assessed by their physician on 03/20/14</p> | F 223 | | | |

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| F 223 | <p>Continued From page 9 and no new orders were given.</p> <p>On 05/01/14, record reviews for Residents #3, #4 and #5 revealed they had been assessed for injuries of unknown injuries and none were found. RN Unit Managers and Supervisors had assessed them. Interview with RN #6 on 05/01/14 at 11:45 AM revealed she and other Unit Managers had completed skin assessments on all residents in the facility on 04/23/14.</p> <p>Review of the inservice logs, on 05/01/14, revealed the Administrator and Director of Nursing were inserviced by the Regional Nurse related to the "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property". Interview with the Administrator and Director of Nursing on 05/01/14 at 10:00 AM verified the inservicing was completed.</p> <p>Review of the policy revision for the Abuse/Neglect and Misappropriation of Resident property, on 05/01/14, verified the revision regarding the assessment of non-interviewable patients for potential abuse during investigations.</p> <p>Review on 05/01/14 of the inservice logs, dated 04/22/14 and 04/23/14, revealed all staff was inserviced related to the revision of the policy on 04/23/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff from different shifts to include five (5) LPNs, an RN and eight (8) CNAs revealed the in-servicing had been provided by the DON, RNs/Unit Managers and Nurse Supervisors for Licensed Nurses and CNAs on "Recognizing and Managing Alzheimer's Type Dementia and was completed on 03/21/14.</p> <p>Review on 05/01/14 of inservice logs dated</p> | F 223 | | | |

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| F 223 | <p>Continued From page 10</p> <p>03/22/14 and 03/23/14, revealed all staff was provided in-service training by the DON, RNs/Unit Managers and Nurse Supervisors on "Caregiver Stress and Burnout" and was completed on 03/22/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff which included five (5) LPNs, an RN and eight (8) CNAs from all shifts, revealed the inservicing had been provided.</p> <p>On 05/01/14 at 11:35 AM, CNA #10 verified through interview that she had received the inservice training by the DON and Unit Manager. The inservice training included the revision of the abuse/neglect policy which included the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 11:40 AM, LPN #1 verified through interview that she had received the inservice training by the DON. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>An interview at 11:45 on 05/01/14 with RN #1 revealed she had received inservice training by the DON and she had also provided some of the training to the CNAs. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for</p> | F 223 | | | |

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| F 223 | <p>Continued From page 11</p> <p>signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 12:05 PM and interview with LPN #3 revealed the DON had provided inservice training on the abuse/neglect policy changes, the types of abuse, stress and staff burnout and managing behaviors of residents with Alzheimer's type behaviors. Care plans for residents with behaviors were also included in the training.</p> <p>An interview on 05/01/14 at 12:05 PM with CNA #11 revealed she had been provided inservice training by the Unit Manager. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>Interview with CNAs #12 and #13 on 05/01/14 at 12:10 PM revealed they had received lots of inservicing by the DON and Unit Managers that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 12:27 PM CNA #14 revealed in interview that she had received inservice training by the Administrative Nurses related to burnout, behaviors of residents, the changes in the abuse</p> | F 223 | | | |

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| F 223 | <p>Continued From page 12</p> <p>policy including residents that were not interviewable.</p> <p>Interview with CNA #15 on 05/01/14 at 12:45 PM revealed she had been provided inservice training by a nurse and the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 12:48 PM, an interview with LPN #5 revealed she had been provided numerous inservice trainings recently that included the policy, resident behaviors and appropriate interventions, staff burnout and what to do.</p> <p>Review of inservice records revealed inservice training had been provided to the DON, RNs, Unit Managers and Clinical Social Workers by the Regional Nurse and Regional Director of Social Service related to Care Planning that covered ensuring interventions related to resident behaviors were care planned as needed. Interviews on 05/01/14 (between 11:15 AM and 4:00 PM) with the DON, RN, Unit Managers and three (3) Licensed Social Workers revealed they had been provided the inservicing which was completed on 04/23/14.</p> <p>Interview on 05/01/14 at 11:15 AM with the Social Service Director revealed she had received inservice training from the Regional Nurse and Regional Director of Social Service related to resident behavior care plans on 04/24/14. The Social Service Director stated she had also</p> | F 223 | | |

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| F 223 | <p>Continued From page 13</p> <p>received the inservice training that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 11:45 AM, an interview with RN #1 revealed she had received inservice training by the Regional Director of Social Service related to resident care plans for behaviors of residents and she had received training by the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>An interview with LPN #1 on 05/01/14 at 11:40 AM revealed she had received inservice training by the Regional Nurse and Regional Director of Social Service on 04/24/14. The training was related to resident care plans for residents with behaviors.</p> <p>Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy and additional four (4) weeks following the 04/22/14 revision. This will be completed by 05/30/14. On 05/01/14, Quality Assurance Monitors dated for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14, 04/22/14 and 04/29/14 were reviewed by the Survey</p> | F 223 | | | |

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| F 223 | <p>Continued From page 14</p> <p>Agency and verified as being completed.</p> <p>Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Review of documented interviews for the weeks of 03/23/14, 04/01/14, 04/15/14, 04/22/14 and 04/29/14 were verified completed.</p> <p>Review of the Quality Assurance Monitors were reviewed by the State Survey Agency on 05/01/14 and included the interviews of fifteen (15) CNAs and five (5) nurses had been completed for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14 and 04/29/14.</p> <p>Ten (10) random care plans will be reviewed weekly for six weeks by RN/Unit Managers for appropriate interventions related to specific behavior care plan. This was verified 05/01/14 per interview with the Director of Nursing and review of the monitors already completed. The monitors will be completed on 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee.</p> <p>The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. This was verified on 05/01/14 by interview and review of in-service records as completed on 03/20/14 by the RNs/Unit Managers/Nurse Supervisors and Department Heads.</p> | F 223 | | | |

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| F 225 F 225 SS=J | Continued From page 15 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | F 225 F 225 | NHC HealthCare, Glasgow does not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, reports any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. Ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation or resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). All alleged violations are thoroughly investigated, and prevents further potential abuse while the investigation is in progress. The results of all investigations are reported to the administrator or his designated representative and to other officials in accordance with State Law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action taken. March 19,2014, DCBS Social Worker came to the Center and stated that she had allegations or rough handling, degrading comments, theft of personal property and medication error involving two residents. DCBS requested that three employees be suspended but stated that she could not tell us why at this time. The Administrator notified the employees of their suspension, contacted both local police and OIG, 03/19/14, to inform them of the allegations and ongoing investigation. During the course of the investigation, DCBS social worker notified the administrator to suspend and additional LPN and CNA. This was done immediately. During the investigation the LPN was cleared and returned to work. One CNA was terminated after admitting to taking 55 dollars from resident Number 2. | 05/03/14 |

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| F 225 | <p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of video recordings, interview, record review and review of the facility's Abuse/Neglect and Misappropriation of Property policy and procedure, it was determined the facility failed to ensure staff reported observed incidents of abuse/mistreatment and assess non-interviewable residents for symptoms of abuse/neglect for one (1) of five (5) sampled residents (Resident #1).</p> <p>Certified Nurse Aides (CNA) were video recorded by a "Nanny Cam" placed in Resident #1's and #2's shared room by a family member. The video recordings revealed inappropriate behaviors of CNAs #1, #2 and #3 (determined by schedule and assignment sheet), who were providing care for Resident #1. The video recordings revealed there were two (2) staff present at all times when care was being rendered to Resident #1 and none of the CNAs reported the recorded events to the Administrator. CNAs were video recorded on different dates, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner after care had been provided. The facility was made aware of the allegations of abuse and neglect on 03/19/14 when the Office of Attorney General and the Department for Community Based Services (DCBS) entered the facility to investigate the allegations; however, the facility failed to assess residents who were unable to speak for themselves for signs/symptoms of abuse/mistreatment.</p> | F 225 | <p>An additional CNA was also terminated. Two CNAs remain suspended awaiting the review of the video. Once the administrator is allowed to review the video, further action will be taken as deemed appropriate.</p> <p>03/19/14, the physician and family for each resident were contacted by the Director of Nursing and informed of the allegation and investigation. The physician came to the center the next day, 03/20/14, and saw each resident. The physician gave no new orders.</p> <p>Overseen by the Regional Nurse, on 04/21/14, RN Units Manager and RN Supervisor conducted resident physical assessments for injuries of unknown origin on both resident #1 and resident #2. No injuries of unknown origin were found. The Regional Nurse, Regional Social Service Director and RN Unit Manager reviewed and updated as needed resident #1 and resident #2 care plans with focus on ensuring that interventions related to specific resident behaviors were care planned as needed. This review was completed on 4/23/14.</p> <p>How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken.</p> <p>Beginning 03/19/14, interviews with all employees were conducted by RNs/Unit Managers, Nurse Supervisors, and Department Heads. As part of their in-service training on the Center's Abuse/Neglect and Misappropriation of Resident Property policy, each employee was asked if they had knowledge of abuse occurring in the center. No employee said that they were aware of abuse occurring in the Center. Those employees that are unavailable/on leave will be interviewed prior to their next shift worked. This was completed on 03/20/14</p> <p>Overseen by the Regional Nurse, on 4/21/14, RNs/ Unit Managers and Nurse Supervisors conducted resident physical assessments for injuries of unknown origin on all residents in the center, no injuries of unknown origin were found.</p> | |

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| F 225 | <p>Continued From page 17</p> <p>The facility's failure to ensure staff reported observed incidents of abuse/neglect/mistreatment and assess non-interviewable residents for signs/symptoms of abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist 01/15/14. The facility was notified of the Immediate Jeopardy on 04/22/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled Policy Regarding Abuse/Neglect and Misappropriation of Resident Property, dated 09/24/09, revealed the policy and procedures shall be in place to prevent resident abuse and neglect. The policy revealed staff observing or hearing about such events will report the event immediately, either verbally or in writing, to their immediate supervisor and any partner having either direct or indirect knowledge of any event that might constitute abuse must report the event to the facility Administrator or their designee immediately.</p> <p>1. Record review revealed the facility admitted Resident #1 on 08/13/09, with diagnoses which included Alzheimer's Disease, Dysphagia and Dementia with Behavior Disturbance.</p> <p>Interview with a family member of Resident #1, on 04/14/14 at 9:45 AM, revealed she had placed a "Nanny Cam" in the resident's room on 01/10/14 to monitor Resident #1's care after facial bruising was identified to the resident's face the first week of January. He/she stated staff was making faces at Resident #1, gesturing like they were going to stick a banana between the</p> | F 225 | <p>Beginning 04/22/14, overseen by the Regional Nurse, RNs/Unit Managers and Nurse Supervisors reviewed and updated as needed, all resident's care plans with focus on ensuring that interventions related to residents behaviors were care planned as needed. This review was completed on 04/23/14.</p> <p>The Measures we have put in Place and Systematic Changes We have Made to Ensure That The Practice Does Not Recur.</p> <p>Overseen by the Administrator, in-service training was conducted by the Department Heads, RNs/Unit Managers and Nurse Supervisors, on the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property," began on 03/19/14 for all employees. In-service training emphasized the employees understanding of the types of abuse, reporting abuse, their role in providing and environment free of abuse, immediately protecting the patient when abuse is witnessed and the signs of employee burn out. Those employees that are unavailable/on leave will be interviewed and in-serviced prior to their next shift worked. This was completed on 03/20/14.</p> <p>04/22/14, the Regional Nurse meet with and in-serviced the Administrator and Director of Nursing regarding "Abuse/Neglect and Misappropriation of Resident Property." They reviewed and updated the Center's " Policy Regarding Abuse/Neglect and Misappropriation of Resident Property.</p> <p>The Center's Policy was updated to included specific assessment of non-interviewable patients for potential abuse during investigations. The Regional Nurse and Administrator contacted the Medical Director and informed him of the policy revision. Following this revision, the Regional Nurse in-serviced Department Heads regarding the revised "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property," on 04/22/14. Then following this in-service, beginning on 04/22/14, overseen by the Regional Nurse, Department Heads conducted in-service training with all employees regarding the center's "Policy Regarding Abuse/Neglect and Misappropriation of</p> | | |

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| F 225 | <p>Continued From page 18</p> <p>resident's legs; pointing their finger in the resident's face; and, holding Resident #1 down while laughing. Further interview revealed the Office of the Attorney General had viewed the video recordings on 03/19/14 and identified the CNAs as CNA #2 and CNA #3 by the schedule and assignment sheets.</p> <p>The SSA Surveyor's review of the video recordings provided by the family member, on 04/16/14, dating from 01/10/14 through 03/12/14 revealed inappropriate behaviors by CNAs #1, #2 and #3 (determined by schedule and assignment sheet), who were providing care for Resident #1. The video recordings revealed there were two (2) staff present at all times when care was being rendered to Resident #1. CNAs were video recorded on different days restraining Resident #1's hands during care, getting in the resident's face and pointing their finger at the resident in a threatening manner after care had been provided. One of the CNAs was observed bending over and biting or kissing the buttocks of the other CNA. Further observation of the video revealed one (1) of the CNAs picked a banana up off the resident's bed side table and made an inappropriate sexual gesture like she was going to stick the banana between the resident's legs; one CNA showed the other CNA her left breast and the other CNA performed a breast exam on herself in front of Resident #1; and, on another occasion Resident #1 repeatedly pushed the cover back from his/her face and one (1) of the CNAs flipped the cover back over the resident's face five (5) different times. The CNA pointed a finger near the resident's face and then made a taunting gesture as the CNA held her hands by her ears while waving her fingers.</p> | F 225 | <p>Resident Property," specifically reviewing the revision in the center's policy regarding assessment of non-interviewable patients for potential abuse during investigations. Those employees that are on leave/unavailable will be in-service prior to their next shift. This was completed on 04/23/14. Overseen by the Director of Nursing, in-service training for licensed nurses was conducted by the DON, RNs/Unit Managers and Nurse Supervisors, on the Nurse's role in administration of Medications and Treatments, began on 03/21/14. In-service training emphasized the nurses understanding in following physician orders, safe administration and documentation. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 03/21/14. Overseen by the Regional Director of Social Services, in-service training was conducted by the DON, RNs/Unit Managers and Nurse Supervisors, with Licensed Nurses and CNAs on " Recognizing and Managing Alzheimer's Type Dementia," began on 03/20/14. In-service training emphasized the nurse's and CNA's understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 03/21/14. Overseen by the Regional Director of Social Services, in-service training was conducted by the DON, RNs/ Unit Managers, and Nurse Supervisors, with Licensed Nurses and CNAs on " Caregiver Stress and Burnout, began on 03/22/14. In-service training emphasized the employees understanding of Common signs and symptoms of caregiver burnout and Dealing with Caregiver Stress and Burnout Prevention Tips. Those employees that are unavailable/ on leave will be interviewed and in-service prior to their next shift worked. This was completed on 03/24/14.</p> | | |

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| F 225 | <p>Continued From page 19</p> <p>Interview with the Administrator and Director of Nursing (DON), on 04/14/14 at 3:15 PM, revealed no staff or residents had reported any abuse/neglect/mistreatment of Resident #1 until 03/19/14 when OAG and DCBS came into the building to investigate.</p> <p>Interview with the Director of Nursing (DON), on 04/16/14 at 3:45 PM, revealed their investigation after being made aware of the allegation of abuse/neglect/mistreatment did not include assessments of non-interviewable residents to determine if any residents had sign/symptoms of abuse/mistreatment.</p> <p>Attempts to contact CNA #1 and CNA #3 on 04/16/14 were unsuccessful due to their telephone numbers were disconnected.</p> <p>A telephone interview with CNA #2, on 04/21/14 at 12:15 PM, revealed CNA #2 revealed she had been suspended and questioned about rough handling of Resident #1. CNA #2 stated she had told the Administrator she did not do it (treat the resident roughly).</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 03/19/14, the facility suspended and then terminated CNAs #1, #2, #3 and #4. CNA #1 was reported to the Nurse Aide Abuse Registry by the Administrator.</p> <p>On 04/21/14, the Regional Nurse provided oversight as Unit Managers assisted by other licensed staff (total of ten) and the RN Supervisor conducted physical assessments for signs/symptoms of possible abuse on all</p> | F 225 | <p>Beginning 04/22/14, the Regional Nurse and Regional Director of Social Service provided Care Planning in-service training for the Director of Nursing, RN/Unit Managers and Clinical Social Workers involved in overseeing the Center's care plan process. The in-service training covered ensuring that inventions related to resident behaviors are care planned as needed. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 04/23/14.</p> <p>The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur.</p> <p>On April 22,2014, The Regional Nurse reviewed with the Director of Nursing the Quality Assurance Monitors that began the week of March 23,2014. Monitors reviewed include;</p> <p>20 random employees per week for 6 weeks will be interviewed for their understanding of the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property." Following the Regional Nurse's review, this monitor will be extened for and additional 4 weeks following the 04/22/14 revision of the policy.</p> <p>10 random Licensed Nurses per week for 4 weeks will be interviewed for their understanding of their role on administration of Medications and Treatments.</p> <p>20 Medication Records per week for 4 weeks will be reviewed for compliance with the Center's policy regarding medication administration.</p> <p>15 random CNAs and 5 random Licensed Nurses per week for 6 weeks will be interviewd for their understanding of recognizing care of residents with dementia with emphasis on their understanding of interacting with and caring for residents with dementia.</p> <p>15 random CNAs and 5 random Licensed Nurses per week for 6 weeks will be interview for their understanding of recognizing Care Giver Burnout. Additionally following the Regional Nurse's review, Overseen by the Regional Nurse and Director of Nursing, two Quality Assurance Monitors,</p> | | |

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| F 225 | <p>Continued From page 20</p> <p>residents including Resident #1; no injuries were found. The care plans for Resident #1 were reviewed and updated with focus on interventions specific to the resident's behaviors.</p> <p>The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy.</p> <p>On 04/22/14, the Regional Nurse in-serviced the Administrator and Director of Nursing regarding the facility's abuse/neglect policy. Together they reviewed and revised the policy to include specific assessment of non-interviewable residents for potential abuse during investigations. The Medical Director was informed of the policy revision. Beginning 04/22/14, all facility employees were inserviced regarding the revision in the policy with employees on leave or were unavailable would have the inservice prior to working their next shift; this was completed on 04/23/14.</p> <p>Inservice training was provided to licensed staff by the DON, RNs and Unit Managers and Nurse Supervisors on recognizing and managing Alzheimer type dementia and emphasized the nurses' and CNAs' understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. This was initiated on 03/20/14 and completed on 03/21/14.</p> <p>Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy including the types of abuse and interviewing residents. An additional four (4)</p> | F 225 | <p>which include care plans on residents with behaviors and non-interviewable residents physical assessments, will begin the week of April 23, 2014. One monitor in which 10 random care plans of residents with behaviors will be reviewed weekly for 6 weeks by RN/Unit Managers and Nurse Supervisors to monitor for appropriate interventions related to their specific behavior care plan. A second Quality Assurance Monitor will be conducted in which residents' physical assessments will be conducted by RN/Unit Managers, and Nurse Supervisors on 10 random non-interviewable residents weekly for 6 weeks to ensure appropriate documentation.</p> <p>The Regional Nurse will review all Quality Assurance monitors with Director of Nursing each month. All Quality Assurance monitors will be reported to the Center's Quality Assurance committee consisting of the Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, and HIM Director monthly. In-service training and Quality Assurance monitors will continue as directed by the Quality Assurance Committee and the Regional Nurse.</p> | | |

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| F 225 | <p>Continued From page 21</p> <p>weeks of monitoring was added following the 04/22/14 revision that included the assessment of non-interviewable residents for potential signs and symptoms of abuse. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Ten (10) random care plans will be reviewed weekly for six (6) weeks by the RN/Unit Managers for appropriate interventions related to specific behavior care plan. The monitors will be completed 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee.</p> <p>The State Survey Agency validated the Corrective action taken by the facility as follows:</p> <p>Record review for Resident #1 and Resident #2, on 05/01/14, revealed Resident #1 and Resident #2 were assessed by their physician on 03/20/14 and no new orders were given.</p> <p>On 05/01/14, record reviews for Residents #3, #4 and #5 revealed they had been assessed for injuries of unknown injuries and none were found. RN Unit Managers and Supervisors had assessed them. Interview with RN #6 on 05/01/14 at 11:45 AM revealed she and other Unit Managers had completed skin assessments on all residents in the facility on 04/23/14.</p> <p>Review of the inservice logs, on 05/01/14, revealed the Administrator and Director of Nursing were inserviced by the Regional Nurse</p> | F 225 | | | |

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| F 225 | <p>Continued From page 22</p> <p>related to the "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property". Interview with the Administrator and Director of Nursing on 05/01/14 at 10:00 AM verified the inservicing was completed.</p> <p>Review of the policy revision for the Abuse/Neglect and Misappropriation of Resident property, on 05/01/14, verified the revision regarding the assessment of non-interviewable patients for potential abuse during investigations.</p> <p>Review on 05/01/14 of the inservice logs, dated 04/22/14 and 04/23/14, revealed all staff was inserviced related to the revision of the policy on 04/23/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff from different shifts to include five (5) LPNs, an RN and eight (8) CNAs revealed the in-servicing had been provided by the DON, RNs/Unit Managers and Nurse Supervisors for Licensed Nurses and CNAs on "Recognizing and Managing Alzheimer's Type Dementia and was completed on 03/21/14.</p> <p>Review on 05/01/14 of inservice logs dated 03/22/14 and 03/23/14, revealed all staff was provided in-service training by the DON, RNs/Unit Managers and Nurse Supervisors on "Caregiver Stress and Burnout" and was completed on 03/22/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff which included five (5) LPNs, an RN and eight (8) CNAs from all shifts, revealed the inservicing had been provided.</p> <p>On 05/01/14 at 11:35 AM, CNA #10 verified through interview that she had received the inservice training by the DON and Unit Manager. The inservice training included the revision of the</p> | F 225 | | | |

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| F 225 | <p>Continued From page 23</p> <p>abuse/neglect policy which included the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 11:40 AM, LPN #1 verified through interview that she had received the inservice training by the DON. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>An interview at 11:45 on 05/01/14 with RN #1 revealed she had received inservice training by the DON and she had also provided some of the training to the CNAs. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 12:05 PM and interview with LPN #3 revealed the DON had provided inservice training on the abuse/neglect policy changes, the types of abuse, stress and staff burnout and managing behaviors of residents with Alzheimer's type behaviors. Care plans for residents with behaviors were also included in the training.</p> <p>An interview on 05/01/14 at 12:05 PM with CNA</p> | F 225 | | | |

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| F 225 | <p>Continued From page 24</p> <p>#11 revealed she had been provided inservice training by the Unit Manager. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>Interview with CNAs #12 and #13 on 05/01/14 at 12:10 PM revealed they had received lots of inservicing by the DON and Unit Managers that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 12:27 PM CNA #14 revealed in interview that she had received inservice training by the Administrative Nurses related to burnout, behaviors of residents, the changes in the abuse policy including residents that were not interviewable.</p> <p>Interview with CNA #15 on 05/01/14 at 12:45 PM revealed she had been provided inservice training by a nurse and the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> | F 225 | | | |

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| F 225 | <p>Continued From page 25</p> <p>On 05/01/14 at 12:48 PM, an interview with LPN #5 revealed she had been provided numerous inservice trainings recently that included the policy, resident behaviors and appropriate interventions, staff burnout and what to do.</p> <p>Review of inservice records revealed inservice training had been provided to the DON, RNs, Unit Managers and Clinical Social Workers by the Regional Nurse and Regional Director of Social Service related to Care Planning that covered ensuring interventions related to resident behaviors were care planned as needed.</p> <p>Interviews on 05/01/14 (between 11:15 AM and 4:00 PM) with the DON, RN, Unit Managers and three (3) Licensed Social Workers revealed they had been provided the inservicing which was completed on 04/23/14.</p> <p>Interview on 05/01/14 at 11:15 AM with the Social Service Director revealed she had received inservice training from the Regional Nurse and Regional Director of Social Service related to resident behavior care plans on 04/24/14. The Social Service Director stated she had also received the inservice training that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>On 05/01/14 at 11:45 AM, an interview with RN #1 revealed she had received inservice training by the Regional Director of Social Service related to resident care plans for behaviors of residents and she had received training by the DON that</p> | F 225 | | | |

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| F 225 | <p>Continued From page 26</p> <p>included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors.</p> <p>An interview with LPN #1 on 05/01/14 at 11:40 AM revealed she had received inservice training by the Regional Nurse and Regional Director of Social Service on 04/24/14. The training was related to resident care plans for residents with behaviors.</p> <p>Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy and additional four (4) weeks following the 04/22/14 revision. This will be completed by 05/30/14. On 05/01/14, Quality Assurance Monitors dated for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14, 04/22/14 and 04/29/14 were reviewed by the Survey Agency and verified as being completed..</p> <p>Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Review of documented interviews for the weeks of 03/23/14, 04/01/14, 04/15/14, 04/22/14 and 04/29/14 were verified completed.</p> <p>Review of the Quality Assurance Monitors were reviewed by the State Survey Agency on 05/01/14 and included the interviews of fifteen (15) CNAs</p> | F 225 | | | |

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| F 225 | Continued From page 27 and five (5) nurses had been completed for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14 and 04/29/14. Ten (10) random care plans will be reviewed weekly for six weeks by RN/Unit Managers for appropriate interventions related to specific behavior care plan. This was verified 05/01/14 per interview with the Director of Nursing and review of the monitors already completed. The monitors will be completed on 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. This was verified on 05/01/14 by interview and review of in-service records as completed on 03/20/14 by the RNs/Unit Managers/Nurse Supervisors and Department Heads. | F 225 | | |
| F 226 SS=J | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of video recordings and the facility's "Abuse/Neglect | F 226 | NHC Glasgow has developed and operationalized policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. March 19,2014, DCBS Social Worker came to the Center and stated that she had allegations or rough handling, degrading comments, theft of personal property and medication error involving two residents. DCBS requested that three employees be suspended but stated that she could not tell us why at this time. The Administrator notified the employees of their suspension, contacted both local police and OIG, 03/19/14, to inform them of the allegations and ongoing investigation. During the | 05/03/14 |

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| F 226 | <p>Continued From page 28</p> <p>and Misappropriation of Property" policy and procedure, it was determined the facility failed to implement the facility's Abuse/Neglect policy and procedure for one (1) of five (5) sampled residents (Resident #1).</p> <p>Certified Nurse Aides were video recorded by a "Nanny Cam" placed in Resident #1's and #2's shared room by a family member. The video recordings revealed inappropriate behaviors of CNAs #1, #2 and #3 (determined by schedule and assignment sheet), who were providing care for Resident #1. The video recordings revealed there were two (2) staff present at all times when care was being rendered to Resident #1 and none of the CNAs reported the recorded events to the Administrator. CNAs were video recorded on different dates, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner after care had been provided. The facility was made aware of the allegations of abuse and neglect on 03/19/14 when the Office of the Attorney General and the Department for Community Based Services (DCBS) entered the facility to investigate the allegations. However, the facility failed to assess residents who were unable to speak for themselves for signs/symptoms of abuse.</p> <p>In addition, the facility failed to identify that Resident #1 had behaviors that might lead to conflict with staff or other residents and failed to develop a care plan with interventions to address the resident's aggressive behaviors with care that placed the resident at an increased risk for abuse.</p> | F 226 | <p>investigation the LPN was cleared and returned to work. One CNA was terminated after admitting to taking 55 dollars from resident Number 2. An additional CNA was also terminated. Two CNAs remain suspended awaiting the review of the video. Once the administrator is allowed to review the video, futher action will be taken as deemed appropriate.</p> <p>03/19/14, the physician and family for each resident were contacted by the Director of Nursing and informed of the allegation and investigation. The physician came to the center the next day, 03/20/14, and saw each resident. The physician gave no new orders.</p> <p>Overseen by the Regional Nurse, on 04/21/14, RN Units Manager amd RN Supervisor conducted resident physical assessments for injuries of unknown origin on both resident #1 and resident #2, no injuries of unknown origin were found. The Regional Nurse, Regional Social Service Director and RN Unit Manager reviewed and updated as needed resident #1 and resident # 2 care plans with focus on ensuring that interventions related to specific resident behaviors were care planned as needed. This review was completed on 4/23/14.</p> <p>How We Have Identified Other Residents Having The Potential To Be Affected By The Same Practice And What Corrective Action Has Been Taken. Beginning 03/19/14, interviews with all employees were conducted by RNs/Unit Managers , Nurse Supervisors, and Department Heads. As part of their in-service training on the Center's Abuse/Neglect and Misappropriation of Resident Property policy. Each employee was asked if they had knowledge of abuse occurring in the center. No employee said that they were aware of abuse occurring in the Center. Those employees that are unavailable/on leave will be interviewed prior to their next shift worked. This was completed on 03/20/14.</p> <p>Overseen by the Regional Nurse, on 4/21/14, RNs/ Unit Managers and Nurse Supervisors conducted resident physical assessments for injuries of unknown origin on all residents in the center. No injuries of unnown origin were found.</p> | | |

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| F 226 | <p>Continued From page 29</p> <p>The facility's failure to implement the procedures in their abuse/neglect policy to protect residents from abuse and misappropriation of property has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist on 01/15/14. The facility was notified of the Immediate Jeopardy on 04/22/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property", dated 09/24/09, revealed the policy and procedures shall be in place to prevent resident abuse, neglect and misappropriation of resident property. Further review revealed staff observing or hearing about such events will report the event immediately, either verbally or in writing, to their immediate supervisor and any partner having either direct or indirect knowledge of any event that might constitute abuse must report the event to the facility Administrator or their designee immediately. The policy also stated residents with needs and behaviors that might lead to conflict with staff or other residents will be identified by the Care Planning Team and will follow through with interventions designed to minimize the risk of conflict or neglect, such as: Residents with a history of aggressive behaviors, residents with communication disorders, and residents who require heavy nursing care, or are totally dependent on nursing care, will be considered as potential victims of abuse. The interventions designed to meet the needs of such residents will include, but will not be limited to identification of residents whose personal histories render them at risk for abusing other residents or staff,</p> | F 226 | <p>Beginning 04/22/14, overseen by the Regional Nurse, RNs/Unit Managers and Nurse Supervisors reviewed and updated as needed, all resident's care plans with focus on ensuring that interventions related to residents behaviors were care planned as needed. This review was completed on 04/23/14. The Measures we have put in Place and Systematic Changes We have Made to Ensure That The Practice Does Not Recurr.</p> <p>Overseen by the Administrator, in-service training was conducted by the Department Heads, RNs/Unit Managers and Nurse Supervisors, on the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property," began on 03/19/14 for all employees. In-service training emphasized the employees understanding of the types of abuse, reporting abuse, their role in providing and environment free of abuse, immediately protecting the patient when abuse is witnessed and the signs of employee burn out. Those employees that are unavailable/on leave will be interviewed and in-serviced prior to their next shift worked. This was completed on 03/20/14. 04/22/14, the Regional Nurse met with and in-serviced the Administrator and Director of Nursing regarding the Center's "Policy Regarding Abuse/ Neglect and Misappropriation of Resident Property." They reviewed and updated the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property." The Center's Policy was updated to included specific assessment of non-interviewable patients for potential abuse during investigations. The Regional Nurse and Administrator contacted the Medical Director and informed him of the policy revision. Following this revision, the Regional Nurse in-serviced Department Heads regarding the revised "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property," on 04/22/14. Then following this in-service, beginning on 04/22/14, overseen by the Regional Nurse, Department Heads conducted in-service training with all employees regarding the center's "Policy</p> | | |

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| F 226 | <p>Continued From page 30</p> <p>assessments of appropriate intervention strategies to prevent occurrences, monitoring the resident for any changes that would trigger abusive behavior and reassessment of the protective strategies on a regular basis.</p> <p>1. Record review revealed the facility admitted Resident #1 on 08/13/09 with diagnoses which included Alzheimer's Disease, Dysphagia and Dementia with Behavior Disturbance. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/20/14, revealed the staff assessed Resident #1's cognition as severely impaired; and, the resident had behaviors of being resistive to care at times with behaviors of kicking, screaming, hitting and smacking at staff during direct care. Review of the Care Plan for Activities of Daily Living, dated 04/02/14, revealed an intervention to "Allow me time to calm down" if (I) become agitated/aggressive. Further review revealed there was no care plan or interventions to address the resident's combative and resistive behaviors to care at times which could place the resident at an increased risk for abuse.</p> <p>Review of the video recordings provided by Resident #1 and Resident #2's family member on 04/16/14 revealed Certified Nursing Aides (CNA) were recorded on different dates (01/10/14 through 03/12/14, on eight different events) with at least two (2) CNAs in the room, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner just inches from his/her face after care had been provided.</p> <p>Interview with the Administrator and Director of Nursing (DON), on 04/14/14 at 3:15 PM, revealed</p> | F 226 | <p>Regarding Abuse/Neglect and Misappropriation of Resident Property," specifically reviewing the revision in the center's policy regarding assessment of non-interviewable patients for potential abuse during investigations. Those employees that are on leave/unavailable will be in-service prior to their next shift. This was completed on 04/23/14. Overseen by the Director of Nursing, in-service training for licensed nurses was conducted by the DON, RNs/ Unit Managers and Nurse Supervisors, on the Nurse's role in administration of Medications and Treatments, began on 03/21/14. In-service training emphasized the nurses understanding in following physician orders, safe administration and documentation. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 03/21/14. Overseen by the Regional Director of Social Services, in-service training was conducted by the DON, RNs/ Unit Managers and Nurse Supervisors, with Licensed Nurses and CNAs on " Recognizing and Managing Alzheimer's Type Dementia," began on 03/20/14. In-service training emphasized the nurse's and CNA's understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 03/21/14.</p> <p>Beginning 04/22/14, the Regional Nurse and Regional Director of Social Service provided Care Planning in-service training for the Director of Nursing, RN/Unit Managers and Clinical Social Workers involved in overseeing the Center's care plan process. The in-service training covered ensuring that interventions related to resident behaviors are care planned as needed. Those employees that are unavailable/on leave will be in-serviced prior to their next shift worked. This was completed on 04/23/14.</p> <p>The Corrective Actions Will Be Monitored To Ensure the Practice Will Not Recur.</p> | | |

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| F 226 | <p>Continued From page 31</p> <p>there had not been any allegations of mistreatment of Resident #1 per the facility's policy until 03/19/14 when OAG and DCBS came into the building to investigate. The Administrator stated he was told by the DCBS representative to suspend three (3) people that included CNA #1, CNA #2 and CNA #3. The Administrator revealed on 04/08/14, the OAG investigator revealed eight (8) to ten (10) video clips to him. The Administrator stated the OAG investigator stated the CNAs behavior was unprofessional and poor technique but did not rise to criminal. The facility suspended those staff and initiated an investigation.</p> <p>Interview with the Director of Nursing (DON), on 04/16/14 at 3:45 PM, revealed when the facility was made aware of the allegations on 03/19/14, the facility did not perform assessments of residents that were not interviewable to assess for any signs or symptoms of possible abuse during their investigation.</p> <p>Interview with the Administrator and DON, on 04/17/14 at 10:15 AM, revealed they ensured compliance with policies by relying on the residents, nurses and staff to report allegations of abuse/neglect. They stated Administrative staff conducted room checks three days a week and abuse and neglect were discussed in care plan meetings and family meetings. They revealed the Unit Managers were also scheduled for surprise visits one (1) time a week which would be a way of ensuring compliance.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 03/19/14, the facility suspended and then</p> | F 226 | <p>On April 22,2014, The Regional Nurse reviewed with the Director of Nursing the Quality Assurance Monitors that began the week of March 23,2014. Monitors reviewed include;</p> <p>20 random employees per week for 6 weeks will be interview for their understanding of the Center's "Policy Regarding Abuse/Neglect and Misappropriation of Resident Property." Following the Regional Nurse's review, this monitor will be extened for and additional 4 weeks following the 04/22/14 revision of the policy.</p> <p>10 random Licensed Nurses per week for 4 weeks will be interviewed for their understanding of their role on adminstration of Medications and Treatments.</p> <p>20 Medication Records per week for 4 weeks will be reviewed for compliance with the Center's policy regarding medication administration.</p> <p>15 random CNAs and 5 random Licensed Nurses per week for 6 weeks will be interviewd for their understanding of recognizing care of residents with dementia with emphasis on their understanding of interacting with and caring for residents with dementia.</p> <p>15 random CNAs and 5 random Licensed Nurses per week for 6 weeks will be interview for their understanding of recognizing Care Giver Burnout. Additionally following the Regioanl Nurse's review, Overseen by the Regional Nurse and Director of Nursing, two Quality Assurance Monitor; which include care plans or residents with behaviors and non- interviewable redients physical assessments, will begin the week of April 23,2014.</p> <p>One monitor in which 10 random care plans of residents with behaviors will be reviewed weekly for 6 weeks by RN/Unit Managers and Nurse Superviors to monitor for appropriate interventions related to their specific behavior care plan. A second Quality Assurance Monitor will be coducted in which resident physical assessment will be conducted by RN/Unit Managers, and Nurse Supervisors on 10 random non-interviewable residents weekly for 6 weeks to ensure appropriate documentation.</p> | | |