

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

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER  BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 225	<p>Continued From page 40</p> <p>nurse was on lunch break. CNA #3 stated when the nurse, LPN #6 returned she told her Resident #1 needed pain medication. She stated she later overheard LPN #6 at the nurse's station say she had told Resident #1 he/she acted like a child by banging the call light. CNA #3 stated the nurse should not have called the resident a child. She stated she thought the incident was mental or verbal abuse; however, had not reported the incident. The CNA indicated she probably should have reported it because if abuse was suspected it was supposed to be reported immediately.</p> <p>Interview, on 04/03/14 at 12:38 PM, with Registered Nurse (RN) #3/ Unit 300 Manager, where Resident #1 resided, revealed she worked dayshift on 03/07/14, 7:00 AM to 3:00 PM. RN #3/Unit 300 Manager stated she was not aware of the incident until 03/10/14. She stated the staff who were aware of the incident should have reported the allegation of abuse immediately.</p> <p>Interview, on 04/10/14 at 3:54 PM, with RN #4/Weekend Supervisor revealed about 8:00 PM on 03/09/14, one (1) of the nurses reported the incident involving Resident #1 and she went and spoke to the resident about it. She stated Resident #1 reported he/she wanted a pain pill, was banging the call light on the table to get attention and LPN #6 screamed at him/her. RN#4/Weekend Supervisor revealed she talked to CNA #7, who was working at the time of the incident, and the CNA stated the nurse had yelled so loudly she heard her at the nurse's station. According to RN #4/Weekend Supervisor, she questioned CNA #7 why she had not reported the incident when it occurred, the CNA told her she was afraid the nurse would be mad at her. RN #4/Weekend Supervisor revealed the incident</p>	F 225	<p>Administrator to the State Abuse Registry or State Agency as per the regulation.</p> <p>5. The Administrator will bring trends identified from the daily review of allegations, complaints and grievances, and employee and resident interviews to the monthly Quality Assurance /Performance Improvement Committee x4 months for further review and recommendations.</p> <p>6. Completion date 5/1/14.</p>	
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F 225	<p>Continued From page 41</p> <p>should have been reported immediately by the CNA and anyone else aware of the incident.</p> <p>Interview, on 04/01/14 at 5:54 PM with SW #1 revealed on 03/17/14, when she spoke to Resident #1 about the incident, the conversation was about the nurse and from the way the resident described the incident she would consider it abuse. SW #1 indicated if staff were aware of the incident it should have been reported immediately to the supervisor.</p> <p>Interview with the DNS on 04/02/14 at 12:30 PM and on 04/04/14 at 5:00 PM, revealed the facility expectation was if staff were aware an abuse event might have occurred they were supposed to report it immediately to their supervisor. The DNS revealed the abuse allegation involving LPN #6 and Resident #1 occurred sometime on nightshift on 03/06/14, to the early morning of 03/07/14, but she was not made aware of the incident until evening shift on 03/09/14 and started the investigation then. She stated the facility's investigation revealed staff did not follow the facility's policy on reporting abuse immediately after witnessing the incident. She stated the staff who were aware did not report the abuse because they were concerned about reporting the nurse involved. The DNS indicated if staff had reported the alleged abuse at the time it occurred the investigation could have been started at that time and the nurse suspended pending the results of the investigation.</p> <p>Interview with the Administrator on 04/02/14 at 1:53 PM, revealed her expectation was any suspected abuse needed to be reported immediately to the supervisor and the supervisor was to call her or her designee. The</p>	F 225			

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F 225	Continued From page 42 Administrator indicated when abuse was reported they were to report to the State Agency, do an investigation and report the findings to the State Agency. The Administrator stated investigating alleged abuse was important to make sure if an employee was involved they were taken out of the equation. She stated the facility's investigation process was to ask the person who reported the alleged abuse and the resident involved what occurred. She stated the process also included collecting witness statements from other staff and sometimes other residents depending on the allegation. Additional interview, on 04/08/14 at 6:46 PM, with the Administrator revealed staff had been aware of the event when it happened and should have reported the alleged abuse immediately. She indicated as a result of staff not reporting the incident immediately, the nurse involved was able to work on night shift on 03/08/14 before Administration was made aware.  Interview, on 04/10/14 at 1:40 PM, with the Manager of Clinical Operations (MCO) revealed the abuse allegations involving Resident #1 and Resident #2 were not reported timely as per facility policy. The MCO indicated she felt the breakdown was due to staff not understanding the abuse policy, on what situations constituted abuse and reporting. In addition, she stated for Resident #2 the breakdown was also at the Administrative level as the facility had interpreted it as a grievance and not as abuse.  The facility provided an acceptable Credible Allegation of Compliance (AOC) on 04/08/14 which alleged removal of the Immediate Jeopardy (IJ) effective 04/07/14. Review of the AOC revealed the facility had implemented the following:	F 225			

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F 225	Continued From page 43	F 225		
	<p>1. The facility's DNS, Administrator and Nurse Supervisors interviewed all interviewable residents to determine if they had experienced or witnessed any abuse in the facility or any issues with receiving PRN medications timely or threatening to have their medication withheld. The facility completed the interviews 03/14/14 and on 04/04/14.</p> <p>2. The facility's DNS and Nurse Supervisors completed assessments of all non-interviewable residents to determine any injury associated with possible abuse. The facility completed the assessments on 03/14/14 and on 04/04/14.</p> <p>3. The DNS and Administrator were re-educated to the Abuse Policy, the timely reporting requirements and completion of a thorough investigation by the MCO on 03/12/14 and on 04/03/14.</p> <p>4. The facility's DNS, Administrator and Nurse Supervisors educated administrative, therapy, dietary, housekeeping, laundry, and maintenance staff on the facility's abuse policy, reporting requirements, promise of confidentiality, and no fear of retribution. Staff was also inserviced on stress management. Employees completed the Abuse Prevention post-test. The facility completed the inservices on 03/14/14 and again on 04/04/14.</p> <p>5. The facility's DNS and Nurse Supervisors educated licensed nurses to count off controlled medications and relinquish med cart keys with another nurse if leaving the facility for lunch breaks or other periods of time to ensure medications were accessible to administer to</p>			

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F 225	<p>Continued From page 44</p> <p>residents as needed. The facility completed the inservices on 03/14/14.</p> <p>6. The facility's DNS and Administrator were responsible for terminating the nurse involved in the allegation of abuse for Resident #1 and reporting the nurse to the Kentucky Board of Nursing. The facility completed the action on 03/14/14.</p> <p>7. The two (2) staff members who heard the incident involving Resident #1, but did not report the allegation received disciplinary action by the DNS and Administrator. The facility completed the action on 03/14/14.</p> <p>8. A Performance Improvement (PI) Meeting, to include the Administrator, DNS and Medical Director was held to discuss the late reporting of the allegation of abuse related to Resident #1 and the plan to correct this. The facility completed this action on 03/14/14.</p> <p>Additionally, a Performance Improvement Meeting, to include the Administrator, DNS and Medical Director, was held to discuss the late reporting of the allegation of abuse related to Resident #2, the Immediate Jeopardy citations, root cause and plan of correction. The facility completed this on 04/04/14.</p> <p>9. The nurse identified in the allegation of abuse for Resident #2 was suspended on 04/03/14. The facility identified the DNS and Administrator as being responsible for the action. The facility completed the action on 04/03/14.</p> <p>10. The initial report of the allegation involving Resident #2 was submitted to the State Agencies</p>	F 225		
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F 225	<p>Continued From page 45</p> <p>on 04/03/14, the persons assigned responsibility were the DNS and Administrator. The facility completed the action on 04/03/14.</p> <p>11. The facility's DNS and Administrator was responsible for interviewing Resident #2 regarding the allegation of abuse reported on 03/02/14. The facility completed the action on 04/04/14.</p> <p>12. The facility's DNS, Administrator and Nursing Supervisors were responsible for interviewing the sister of Resident #2 regarding the allegation of abuse reported on 03/02/14. The facility completed the action on 04/04/14.</p> <p>13. The facility's DNS, Administrator and Nurse Supervisors were responsible for interviewing employees who worked 7:00 AM to 3:00 PM on 03/02/14 regarding the allegation of abuse related to Resident #2. The facility completed the interviews on 04/05/14.</p> <p>14. The facility's DNS and Nurse Supervisors were responsible to enter the allegation of abuse for Resident #2 into the Risk Management System (RMS). The facility completed the action on 04/04/14.</p> <p>15. The facility's DNS, Nurse Supervisors and Administrator were responsible to provide education to new hires on the facility's abuse policy, reporting requirements, promise of confidentiality, and no fear of retribution during orientation. This was an ongoing action. The facility did not use agency staff.</p> <p>16. The facility was to assign supervisors on each shift to monitor staff and resident interactions and</p>	F 225		

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F 225	<p>Continued From page 46</p> <p>to determine any allegations of abuse were reported immediately to the Administrator. The facility's Administrator and DNS were responsible to implement the action and the facility completed on 04/04/14.</p> <p>17. The facility was to implement monitoring actions to include interview of five (5) employees weekly for four (4) weeks and then monthly for three (3) months to determine: staff understood the facility's abuse policy; understood reporting allegations to the Administrator immediately; and understood allegations or statements were kept confidential and there was no fear of retribution for reporting. Any concerns were to be addressed at the time of interview. The facility identified the DNS, Nurse Supervisors and Administrator as being responsible for the audits which were ongoing.</p> <p>18. The facility was to implement monitoring actions to include interview of five (5) residents weekly for four (4) weeks and then monthly for three (3) months to determine any issues with staff treatment or abuse and any issues with withholding of medication. Any concerns identified were to be addressed at that time. The facility identified the Administrator as being responsible for he audits and they were ongoing.</p> <p>19. The facility was to implement monitoring actions to include an audit of all abuse investigations to determine that abuse allegations were reported timely as per the abuse policy and the investigations were thoroughly completed. Any concerns identified during the audit were to be addressed at that time. The facility identified the Administrator as being responsible for the audits and they were to be ongoing.</p>	F 225		
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F 225	<p>Continued From page 47</p> <p>20. The findings of the monitoring identified above were to be reported to the Performance Improvement Committee monthly for four (4) months for further review and recommendation. The Administrator and DNS were responsible and this was to be ongoing.</p> <p>21. The facility was to perform an audit on abuse allegations identified for the prior thirty (30) days, 03/06/14 through 04/06/14, to assure a thorough investigation was completed and any abuse was reported timely as per the facility policy. The person responsible was the MCO and the facility was to complete this on 04/07/14.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Interview and review of the facility's AOC implementation documentation for Resident #1 and Resident #2, with the DNS on 04/10/14 at 10:37 AM, 12:13 PM and at 1:16 PM, revealed the facility used a Resident Census Report to identify all interviewable residents. The resident interviews were performed by the DNS and Nursing Supervisors which included Unit Managers. Reviewed the documented resident interviews all completed by 03/14/14 and 04/04/14.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 04/10/14 at 4:27 PM, and RN #5/100 Unit Manager on 04/10/14 at 4:48 PM revealed resident interviews were performed as per the AOC.</p> <p>Interview on 04/10/14, with Resident #1 at 12:58 PM; Resident #2 at 10:19 AM; Unsampled</p>	F 225		
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F 225	<p>Continued From page 48</p> <p>Resident A at 5:05 PM; Unsampld Resident B at 4:49 PM; and Unsampld Resident C at 5:10 PM revealed they were all interviewed by facility staff two (2) different times recently about abuse and medications.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she was in charge of the AOC plan to make sure everything was completed as indicated and verified all the resident interviews were completed by the 03/14/14 and 04/04/14 as noted on the AOC.</p> <p>2. Interview and review of the facility's AOC implementation documentation with the DNS on 04/10/14 at 10:37 AM, 12:13 PM and at 1:16 PM, revealed the facility used a Resident Census Report to identify all non-interviewable residents. The DNS stated they had two (2) staff present for skin assessments and no problems were identified indicating abuse, such as, bruises, scratches, any type of redness or any signs they were not getting care. Review and interview with the DNS revealed the skin assessments were performed by the DNS and Nursing Supervisors on 03/13/14, 03/14/14 and again on 04/04/14 with no issues identified.</p> <p>Interview with the ADON on 04/10/14 at 4:27 PM and RN #5/100 Unit Manager at 4:48 PM, revealed skin assessments were performed on non-interviewable residents.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she had verified all skin assessments of non-interviewable residents were completed by 03/14/14 and 04/05/14 as noted on the AOC with no issues identified.</p>
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F 225	Continued From page 49 3. Review of a documented inservice on 03/12/14 and 04/03/14 revealed the DNS and Administrator were re-educated on the facility's abuse policy and reporting requirements by the MCO.  Interview with the DNS on 04/10/14 at 12:13 PM, and the Administrator on 04/10/14 at 5:29 PM, revealed both had received an inservice on the abuse policy and reporting requirements on 03/12/14 and 04/03/14 by the MCO.  4. Interview and review of the facility's AOC implementation documentation for Resident #1 and Resident #2, with the DNS on 04/10/14 at 10:37 AM, at 12:13 PM and at 1:16 PM, revealed the facility used a master list of employees to inservice all staff on 03/10/14 thru 03/14/14 and on 04/03/14 thru 04/04/14. The DNS stated staff inservices included review of the abuse policy which included examples of abuse and reporting, investigations and reporting were confidential, stress management, and abuse post-test. She further stated inservices were performed by the Administrative team which included herself, the Administrator and Nursing Supervisors. The DNS stated staff who were not present were contacted by phone and given the inservice on the abuse policy and stress management. She indicated staff who the facility was unable to contact by phone were sent the inservice education by certified mail. The list of staff who were sent the inservice education by certified mail and the certified mail receipts were reviewed. Interview with the DNS revealed when the staff who were not present at the inservice came in to work they went over the post test and signed inservice sheets prior to beginning work. She stated the inservices were performed by the Administrative team which included herself, the	F 225			

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F 225	Continued From page 50 Administrator and Nursing Supervisors.  Review of the AOC implementation documentation revealed a master list of employees which showed staff were inserviced from 03/10/14 through 03/14/14 and on 04/03/14 and 04/04/14, on the abuse policy, reporting requirements, promise of confidentiality, no fear of retribution and stress management. The inservice material and post-tests completed by employees after the inservicing were reviewed.  Interview on 04/10/14 with the ADON at 4:27 PM; RN #4/Weekend Supervisor at 4:08 PM; Activities Director at 2:44 PM; the Employee Benefits and Payroll Coordinator at 3:13 PM; the Maintenance Director at 3:39 PM; and RN #5/100 Unit Manager at 4:48 PM revealed they had inserviced staff on the facility's abuse policy and stress management in March and April.  Staff interviews on 04/09/14 with LPN #10 at 5:22 PM; CNA #18 at 5:30 PM; LPN #11 at 5:41 PM; CNA #14 at 5:51 PM; CNA #3 at 6:55 PM; and, on 04/10/14 with LPN #12 at 7:30 AM; LPN # 13 at 7:50 AM; LPN # 14 at 7:55 AM; Dietary Aide #1 at 2:05 PM; Housekeeping #1 at 2:18 PM; Dietary Aide #2 at 2:27 PM; Housekeeping #2 at 2:32 PM; Activities Director at 2:44 PM; Maintenance #1 at 2:55 PM; Laundry #1 at 3:04 PM; Employee Payroll and Benefits Coordinator at 3:13 PM; Occupation Therapist (OT) #1 at 3:21 PM; Physical Therapy Assistant (PTA) #1 at 3:26 PM; CNA #16 at 3:33 PM; Maintenance #2 at 3:39 PM; CNA #17 at 3:47 PM; RN #4/Weekend Supervisor at 4:08 PM; and LPN #15 at 4:17 PM revealed all indicated they had received inservices on abuse in March and April which included the types of abuse, how and when to	F 225			

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F 225	<p>Continued From page 51</p> <p>report abuse, confidentiality/retribution, and stress management.</p> <p>5. Interview and review of the facility's AOC implementation documentation for Resident #1, with the DNS on 04/10/14 at 12:13 PM and at 1:16 PM, revealed the facility used a master list of nurses identified as receiving inservice education on 03/13/14 and 03/14/14 on counting controlled medications in the medication carts and giving the medication cart keys to another nurse before leaving the facility for lunch breaks. She stated the inservices were performed by herself and the Nursing Supervisors.</p> <p>Interview on 04/10/14 with DNS and ADON at 4:27 PM, RN #4/Weekend Supervisor at 4:08 PM, Activities Director at 2:44 PM, and RN #5/Unit Manager 100 at 4:48 PM revealed they inserviced staff on abuse in March and when applicable nursing staff on med cart.</p> <p>Staff interviews on 04/09/14 with LPN #10 at 5:22 PM; LPN #11 at 5:41 PM; and on 04/10/14 with LPN #12 at 7:30 AM; LPN #13 at 7:50 AM; LPN #14 at 7:55 AM; RN #4/Weekend Supervisor at 4:08 PM; and LPN #15 at 4:17 PM revealed all indicated they had received inservices on counting controlled medications in the medication carts and on giving the medication cart keys to another nurse prior to leaving the facility for lunch breaks in March.</p> <p>Interview with the Administrator, on 04/10/14 at 5:29 PM, revealed nurses were inserviced staff as indicated on the AOC in March.</p> <p>6. Review of the facility's report of LPN #6 to KBN revealed the nurse was reported on 03/21/14.</p>	F 225		
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F 225	<p>Continued From page 52</p> <p>Personnel record review revealed LPN #6 was terminated from employment.</p> <p>Interview with the DNS on 04/10/14 at 1:16 PM and the Administrator at 5:29 PM, revealed LPN #6 was terminated on 03/17/14 per the AOC and reported to KBN by the DNS.</p> <p>7. Interview with the DNS on 04/10/14 at 1:16 PM and the Administrator at 5:29 PM, revealed the two (2) staff who did not report the abuse of Resident #1 received final written warnings by the DNS for not reporting timely. The final written warnings for CNA #3 and CNA #7 were reviewed.</p> <p>Interview with CNA #7 on 04/02/14 at 8:55 AM and CNA #3 on 04/09/14 at 6:58 PM, revealed they were counseled by the facility about reporting abuse sooner.</p> <p>8. Review of the PI meeting sign in sheets dated 03/14/14 and 04/04/14, revealed it was signed by Administrator, DNS and Medical Director.</p> <p>Interview with the Medical Director on 04/09/14 at 4:13 PM, revealed he attended the PI meeting in March about the allegation of abuse involving Resident #1 and a nurse. He stated they discussed what happened and an action plan on how to prevent it from happening again. Additionally, the Medical Director stated he attended the PI meeting in April regarding the allegation of abuse involving Resident #2 and in the meeting they had discussed the Immediate Jeopardy related to the abuse incident and the action plan to prevent reoccurrence.</p> <p>Interview with the DNS on 04/10/14 at 12:13 PM and the Administrator at 5:29 PM, revealed they</p>	F 225		

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F 225	Continued From page 53 attended the March and April PI meeting with the Medical Director and discussed the allegation of abuse and action plan related to Resident #1 and Resident #2 and also discussed the Immediate Jeopardy and action plan in April.  9. Review of LPN #1's "Timecard" punches revealed the nurse clocked out on 04/03/14 at 2:04 PM.  Interview with the DNS on 04/10/14 at 10:37 AM and Administrator at 5:29 PM revealed LPN #1 was suspended on 04/03/14.  10. Review of the initial faxed report sent to the State Survey Agency regarding the 03/02/14 abuse allegation involving Resident #2 and LPN #1 was sent on 04/03/14 by the Administrator.  Interview with the Administrator on 04/10/14 at 5:29 PM confirmed she sent the faxed report on 04/03/14.  11. Review of an interview with Resident #2 was completed on 04/04/14 as indicated on the AOC plan.  Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM revealed they interviewed Resident #2 on 04/04/14, and he/she confirmed the nurse threatened not to give the resident pain medication.  Interview with Resident #2 on 04/10/14 at 10:19 AM, revealed the DNS and Administrator talked to him/her about the phone incident and pain medication.  12. Review of the facility's documented interview	F 225		

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F 225	<p>Continued From page 54</p> <p>with Resident #2's sister revealed it was performed on 04/04/14 as indicated on the AOC.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she interviewed Resident #2's sister on 04/04/14, and she asked about the incident. The Administrator stated the sister already knew about the allegation, but thought the nurse was trying to limit the resident's phone calls to her as requested. Interview with DNS on 04/10/14 at 12:13 PM revealed the Administrator interviewed the resident's sister.</p> <p>13. Review of witness statements of employees who worked from 7:00 AM to 3:00 PM on 03/02/14 were reviewed by comparison with the 03/02/14 dayshift schedule.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM and 12:13 PM and the Administrator at 5:29 PM, revealed all staff who worked dayshift on 03/02/14 were interviewed mostly by the DNS and were asked did you hear a nurse yell or scream at a resident and did you hear a nurse threaten to withhold medication.</p> <p>Interview with the ADON on 04/10/14 at 4:27 PM, revealed she interviewed some of the staff who worked on 03/02/14 about the allegation.</p> <p>Interview with CNA #11 on 04/09/14 at 3:05 PM and with LPN #4 at 3:15 PM, revealed they had worked on 03/02/14 and were interviewed by the facility about the event on 04/04/14.</p> <p>14. Interview with the DNS on 04/10/14 at 10:37 AM and review of the facility's AOC implemented for Resident #2 revealed the facility entered the allegation of abuse for Resident #2 into the Risk</p>	F 225		

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F 225	<p>Continued From page 55 Management System on 04/04/14.</p> <p>15. Review of the AOC documentation revealed the facility had new employees who were inserviced on 04/07/14 on the abuse policy, reporting requirements, promise of confidentiality and no fear of retribution.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM, revealed the facility had several newly hired staff who were interviewed on 04/07/14 regarding their inservice.</p> <p>Interview with the Administrator 04/09/14 at 1:28 PM, revealed the facility does not use agency staff.</p> <p>16. Review of the facility's work schedule 04/04/14 through 04/06/14 revealed the facility had supervisors on each shift.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed supervisors were assigned to each shift to monitor for abuse and were supposed to monitor interactions between residents and employees to ensure they were appropriate. They indicated if there was an allegation reported to the supervisor it was to be reported immediately to the Administrator.</p> <p>Interviews on 04/10/14 with the Maintenance Director at 3:39 PM; the ADON at 4:27 PM; RN #4/100 Unit Manager at 4:48 PM; Employee Benefits and Payroll Coordinator at 3:13 PM; and Activities Director at 2:44 PM revealed they all had a list of shifts and they picked up different shifts to observe and supervise interactions of employees and residents and if a suspected</p>	F 225		

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F 225	Continued From page 56 allegation of abuse was identified they were to call the DNS and Administrator immediately. The staff indicated no abuse allegations had been identified.  17. Reviewed the audit tool which was to be utilized for employee abuse interviews.  Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the facility had implemented audits to interview five (5) employees weekly for four (4) weeks and then monthly for three (3) months to determine if staff understood the abuse policy and reporting of all allegations of abuse. Continued interview revealed audits had been initiated and would be done by Administrator, DNS or Nursing Supervisors Monday through Friday, and staff would be re-educated if concerns were identified.  Interview, on 04/10/14 at 4:27 PM, with the ADON revealed she had interviewed some employees for the abuse audits and they were supposed to do five (5) employees each week. The ADON indicated if she identified a problem during the audit she was to address it at that time; however had not identified a problem in her abuse audits.  18. Reviewed the audit tool which was to be utilized for resident interviews.  Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the facility had implemented the audits to interview five (5) residents weekly for four (4) weeks and then monthly for three (3) months to determine any issues with staff treatment and any withholding of medication. Continued interview with the DNS and Administrator revealed audits	F 225			

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F 225 Continued From page 57  
had been initiated and residents were to be interviewed by the Administrator, DNS and Nursing Supervisors Monday through Friday.

Interview on 04/10/14 at 4:27 PM, with the ADON revealed she had performed resident interviews for the audits and they were supposed to do five (5) per week. She indicated if a concern was identified it was to be addressed at the time of interview; however, had not identified any concerns in her resident interview audits.

19. Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the facility did not have a specific form for auditing the abuse investigation but the Administrator would be performing audits on all abuse investigations to determine if the allegations were reported timely, investigations were thoroughly completed and the Initial report was sent to the State Survey Agency in twenty-four (24) hours and the five (5) day follow up was sent in timely. Continued interview with the DNS and Administrator revealed any concerns would be addressed at that time.

20. Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the audit data would be presented to the monthly PI Committee meetings by the Administrator or DNS for four (4) months as indicated in the AOC. Continued interview with the DNS and Administrator revealed they have not yet had the monthly PI Committee meeting.

21. Interview, on 04/10/14 at 1:40 PM, with the MCO revealed her role was to review prior abuse investigations from 03/06/14 to 04/06/14, to ensure the investigations were done, were

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F 225	Continued From page 58 thorough and incidents were reported in a timely manner per the facility's abuse policy. Continued interview with the MCO revealed she had audited five (5) incidents, including those involving Resident #1 and #2, and reported those were the only problematic events.	F 225	1. The allegation of abuse regarding Resident #2 was reported to the appropriate state agencies LPN #1 was suspended on 4-3-14 by the Administrator and Director of Nursing. The investigation was completed and the final report was submitted to the appropriate state agencies on 4/8/14 by the Administrator. LPN#1 was terminated on 4/14/14 by the Director of Nursing.  The allegation of abuse regarding Resident #1 was reported to the appropriate state agencies and the LPN #6 was suspended on 3-9-14. The investigation was completed and the final report was submitted to the appropriate state agencies on 3/14/14 by the Administrator. LPN #6 was terminated on 3/17/14 by the Director of Nursing.  Residents' #1 and #2 have had no additional allegations of abuse.	5/1/14	
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 the facility's policy and grievance forms, it was determined the facility failed to have an effective system in place to ensure policies and procedures were implemented related to abuse for two (2) of seven sampled residents (Resident #2 and Resident #1). The facility failed to ensure staff reported allegations of abuse, failed to identify allegations of abuse, failed to investigate allegations of abuse, failed to prevent the potential for further abuse, and failed to report the allegation to appropriate State Agencies per the facility's policy and procedures. (Refer to F-223 and F-225)  Resident #2 informed Licensed Practical Nurse (LPN) #4 on 03/02/14, another nurse, LPN #1 had "snatched" the phone from him/her and told the resident he/she allowed to use the phone. Resident #2 reported to LPN #4 that LPN #1 told	F 226			

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F 226	Continued From page 59  him/her if he/she continued to curse she would not give the resident his/her pain medication. LPN #4 completed a Grievance/Concern Report, called the Director of Nursing Services (DNS) and gave copies of the grievance form to the Administrator, DNS and Social Services (SS). However, the facility considered the incident a grievance, not potential abuse and failed to thoroughly investigate the incident to include interviews with other residents and staff. Therefore, LPN #1 was suspended for only one (1) day and then allowed to continue providing care for residents which could have resulted in the potential for further abuse. The facility also failed to report the incident to the appropriate State Agencies.  Additionally, in the early morning hours of 03/07/14, two (2) Certified Nursing Assistants (CNAs), who had been trained on the facility's abuse policy, witnessed verbal abuse of Resident #1 by LPN #6. The CNAs heard LPN #6 yell at Resident #1 due to him/her using the call light multiple times to ask for pain medication. The CNAs also heard LPN #6 inform Resident #1 he/she was acting like a child and banging the call light would not get the pain medication administered any faster. After witnessing the verbal abuse the CNAs failed to immediately report it as per facility policy. Therefore, LPN #6 was allowed to work an entire night shift on 03/08/14, caring for residents which put them at risk for further potential abuse by the LPN. Administration was not notified until the evening shift of 03/09/14, after the resident's family filed a grievance. Because the CNAs did not immediately report the alleged abuse, an abuse investigation was not conducted within twenty-four (24) hours and the incident was not	F 226	2. Director of Nurses, Administrator, and Nurse Supervisors have interviewed alert and oriented residents from 3/13/14 to 4/4/14 to determine if the resident has experienced or witnessed any abuse in the center or any issues with receiving PRN medications timely with corrective action if indicted upon discovery.  Allegations of abuse were reported to the appropriate state agencies within 24 hours of being reported to the interim administrator.  Director of Nurses and Unit Managers completed an assessment of non-interviewable residents from 3/12/14 to 4/4/14 to determine any injury associated with possible abuse with no corrective action required.		

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F 226	<p>Continued From page 60 reported to State Agencies until 03/10/14.</p> <p>The facility's failure to have an effective system in place to ensure policies and procedures were implemented related to abuse was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 04/03/14 and was determined to exist on 03/02/14.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/08/14 with the facility alleging removal of the Immediate Jeopardy on 04/07/14. The Immediate Jeopardy was verified to be removed on 04/07/14 as alleged, prior to exit from the facility on 04/10/14, with remaining non-compliance at a Scope and Severity of "D", while the facility develops and implements the Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure residents are free from abuse.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "OPS310 KY Abuse Prohibition", effective 07/01/13, revealed the facility prohibited abuse for all residents through: identification of possible incidents or allegations which required investigation; investigation of incidents and allegations; protection of residents during investigations; and reporting of incidents and investigation results. The policy revealed staff who witnessed an incident of suspected abuse were to report the incident immediately to his/her supervisor and the supervisor was to report the suspected abuse immediately to the Administrator or designee. The policy noted upon receiving information concerning a report of suspected or alleged</p>	F 226	<p>3. Director of Nurses, Administrator, Nurse Management, and Human Resources will have provided reeducation as of 4/30/14 with the administrative, nursing, therapy, dietary, housekeeping, laundry, and</p> <p>maintenance staff regarding an effective system that ensures each resident remains free of abuse:</p>	
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F 226	<p>Continued From page 61</p> <p>abuse the Administrator or designee would fax a report to the appropriate State Agencies. Review of the policy revealed any employee alleged to have committed an act of abuse was to be immediately removed from duty pending investigation. In addition, policy review revealed the facility was to initiate an investigation within twenty-four (24) hours of an allegation of abuse that focused on whether the abuse occurred and to what extent.</p> <p>1. Review of the facility's "Grievance/Concern Report", completed on 03/02/14, by LPN #4 revealed Resident #2 told her when trying to use the phone LPN #1 "snatched" the phone, hung it up and told the resident he/she was not allowed to use the phone. Continued review of the "Grievance/Concern Report" revealed Resident #2 had also reported LPN #1 told the resident if he/she continued to curse at the LPN she would not give the resident his/her pain medication. Review revealed LPN #1 was suspended on 03/03/14 and then allowed to return to work after education on "Customer Service" and re-education on resident rights and the facility's abuse policy. Review of the "Grievance/Concern Report" revealed the grievance was noted as resolved on 03/04/14 by the DNS as Resident #2 and LPN #1 denied "pain meds would be withheld". Further review revealed no documented evidence the facility completed an abuse investigation as per facility policy or evidence the alleged abuse was reported to the State Agencies within twenty-four (24) hours as per the policy. Additionally, there was no documented evidence other residents or staff were interviewed.</p> <p>Interview with Resident #2 on 04/03/14 at 2:30</p>	F 226	<ul style="list-style-type: none"> <li>Center Abuse policy including need to protect the resident from potential risk at the time and during the investigation.</li> <li>Reporting requirements including immediate reporting to the Administrator and appropriate state agencies;</li> <li>Promise of confidentiality and no fear of retribution. Including stress management strategies for staff.</li> </ul>	
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F 226 Continued From page 62  
PM, revealed LPN #1 grabbed the phone from his/her ear, slammed it down on the receiver, and said "wait until you want another pain pill". Resident #2 reported he/she told LPN #4 what LPN #1 had done and LPN #4 had indicated to the resident it was a grievance.

Interview, on 04/02/14 at 2:39 PM, with CNA #10 revealed she had overheard LPN #1 telling Resident #2, on 03/02/14, that he/she would not get his/her medicine on time because the resident was not doing what he/she was supposed to do. CNA #10 indicated she talked to LPN #4 about what she had overheard and LPN #4 told her she was going to call the DNS. CNA #10 stated she felt the facility had not properly investigated the incident as she was never interviewed about it. However, the facility's policy and procedures stated the facility would investigate incidents and allegations.

Interview, on 04/09/14 at 3:05 PM, with CNA #11 revealed the facility's policy was when there was an allegation of abuse which involved an employee, the employee was suspended and the facility did an investigation at the time. CNA #11 stated she witnessed Resident #2 trying to use the phone at the nurse's station and LPN #1 told the resident he/she was not allowed to use the phone. She stated she observed LPN #1 grab the phone from Resident #2's hand and slam it down on the receiver which startled the CNA. CNA #11 revealed the nurse also told Resident #2 if he/she tried to use the phone again she was not going to give his/her pain medication. She stated she felt this was verbal/mental abuse and maybe physical abuse as the LPN had jerked the phone from Resident #2's hand. CNA #11 stated she did not report the incident because LPN #4, who

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- Employee competency assured using the Abuse Prevention post-test.
- Licensed nurses provided reeducation regarding the need for licensed nurses to count off controlled medications and relinquish med cart keys with another nurse if leaving the center for lunch or other periods of time to ensure that medications are accessible to residents as needed.
- The Director of Nurses

and Administrator were reeducated 3/12/14, 4/4/14 and 4/30/14 by the Manager of Clinical Operations regarding Abuse Policy and reporting requirements.

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F 226	<p>Continued From page 63</p> <p>was aware of the incident, was going to take care of it. She stated the facility's normal process was to suspend an employee involved in an allegation of abuse and investigate it at that time. CNA #11 reported the facility had not contacted her regarding the incident at the time.</p> <p>Interview, on 04/02/14 at 11:36 AM, with LPN #4 revealed on 03/02/14, Resident #2 reported LPN #1 had "snatched" the phone from him/her and told the resident he/she couldn't use the phone anymore. LPN #4 stated Resident #2 reported being upset when this happened and had cursed the nurse. LPN #4 reported Resident #2 told her LPN #1 stated if the resident kept talking to her like that she would not give him/her pain medication. LPN #4 reported she felt LPN #1's actions were abuse and so she called the DNS to inform her. LPN #4 stated the DNS told her she would take care of the incident. LPN #4 indicated the facility's policy was to investigate allegations of abuse which included interviewing residents and staff. However, she stated the facility did not interview her about the incident. In addition to calling the DNS, the LPN stated she completed a grievance form, attached a statement and gave one (1) to the Administrator, the DNS and SS.</p> <p>Interview with Social Worker (SW) #1 on 04/03/14 at 1:57 PM and 2:53 PM, and on 04/08/14 at 6:02 PM, revealed she did receive a copy of the grievance and read it somewhere between the week of 03/03/14 and 03/08/14. She stated she was concerned after reading it because the content stated the nurse "snatched" the phone from Resident #2, and told the resident if he/she continued to curse she would not give his/her pain medication. SW #1 stated she had discussed the grievance, her concern and what to</p>	F 226	<ul style="list-style-type: none"> <li>Employees upon hire and/or not working during this timeframe will have education/ reeducation by administrative management to the center's abuse policy, reporting requirements, promise of confidentiality and no fear of retribution and will be repeated annually with all staff.</li> <li>Facility does not use agency staff.</li> </ul> <p>4. Administrator and Director of Nurse have assigned supervisors across the 3 shifts daily (includes Saturday and Sunday) to observe staff/resident interaction, and to determine that any allegations are reported immediately to the Administrator as of 4/4/14. Any concerns with staff interaction or allegations identified will be called to the Administrator/DNS by the</p>		

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do next with the Administrator and DNS around that time. SW #1 stated she could not remember what all was discussed or if she identified the grievance as an abuse allegation or only a concern. Per interview SW #1, revealed on 04/03/14 she interviewed Resident #2 who told her a nurse had informed him/her she was not going to give his/her pain medication if he/she tried to use the phone again. The Social Worker stated, based on Resident #2's interview, it sounded like abuse and the facility should have followed the abuse policy and did a more thorough investigation when the incident first occurred on 03/02/14. SW #1 stated resident safety was a concern because the LPN involved continued to work.

Interview, on 04/02/14 at 12:30 PM and on 04/03/14 at 5:34 PM, with the DNS revealed she did not receive a phone call regarding the incident. However, LPN #4 had stated she called the DNS. The DNS stated a copy of the grievance form was in her mailbox on 03/03/14. She stated initially she had thought it was abuse and suspended LPN #1. The DNS stated she interviewed Resident #2 two (2) times and he/she denied the nurse aggressively removing the phone from his/her hand and threatening his/her pain medication. She stated she also got a written statement from LPN #1 who denied the incident. The DNS stated based on the interviews with Resident #2 and LPN #1, she did not think it was abuse after all. However, in looking back at the incident she felt it was an allegation of abuse and should have been investigated as per the policy. The DNS indicated there had been a breakdown in the process from the first day of the incident and the facility's abuse investigation process was not followed and the

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Shift Supervisor for review to determine any action to be taken including reporting to the state agency if indicated.

Administrator, Director of Nursing, and Nurse Supervisors will interview 5 employees from all departments weekly x4 weeks and then monthly x3 months then as determined by the monthly Quality Assurance /Performance Improvement Committee to determine staff understanding of the abuse policy, reporting allegations to the Administrator immediately, and that allegations or statements are kept confidential with no fear of retribution for reporting. Concerns identified will be addressed upon discovery.

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F 226	Continued From page 65 Administrator was not notified immediately. According to the DNS, if a full investigation of an abuse allegation was not completed and the alleged perpetrator was allowed to continue working there was a potential for additional abuse by the employee. The DNS reported the facility had re-opened an investigation into the alleged abuse and LPN #1 had been suspended.  Review of LPN #1's "Timecard" punched revealed the nurse did not work on 03/03/14. Further review revealed she worked 03/04/14 through 03/06/14; 03/15/14 through 03/17/14; 03/24/14 through 03/27/14; 03/29/14 through 03/31/14; and 04/02/14.  2. Review of the facility's, "Self-Reported Incident Form 5 Day Follow up/Final Report", dated 03/14/14, revealed on 03/09/14, Resident #1's family had turned in a grievance form which indicated a nurse had talked "unprofessionally" to the resident. Review of the Incident Form revealed the resident had a tracheotomy (trach) and to make his/her needs known mouthed words. Review of the incident Form revealed Resident #1, on the morning of 03/07/14, had used his/her call light multiple times and banged the call light on a table to request medication. Continued review of the Incident Form revealed the nurse was on break and when she returned she went to Resident #1's room and told the resident he/she was going to listen to her and told the resident he/she was bothering other residents by making so much noise. Review of the Incident Form revealed the nurse told the resident this behavior would not get his/her pain medication any quicker. Further review of the Incident Form revealed staff interviews indicated they heard the nurse yelling at the resident and telling him/her	F 226	Administrator, Director of Nurses and Nurse Supervisors will interview 5 residents weekly x4 weeks and monthly x3 months to determine any issues with staff treatment or abuse and any issues with withholding of medication. Concerns identified will be addressed upon discovery.  Administrator and/or Social Services, or Shift Supervisors will review grievances, complaints and allegations daily (includes Saturday and Sunday) times 4 weeks then as determined by the monthly Quality Assurance /Performance Improvement Committee to determine that Abuse allegations are reported timely, resident is protected from further potential abuse as per the Abuse Policy and that investigations are thoroughly completed. Concerns identified will be addressed upon discovery.	

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that hitting the bedside table would not get assistance any faster. In addition, review of the Incident Form revealed a staff person reported LPN #6 came back from Resident #1's room stating she had told the resident to quit ringing the call light every few minutes and the called Resident #1 a child.

Interview with Resident #1 on 04/01/14 at 2:16 PM and on 04/02/14 at 4:15 PM and 5:14 PM, revealed on night shift one (1) night a nurse had yelled at Resident #1. Resident #1 indicated it had taken three (3) hours to get his/her pain medication. Resident #1 revealed because he/she was banging the call light this nurse got upset and told the resident he/she was acting like a kid. Further interview revealed Resident #1 was scared when the nurse yelled at him/her and it made him/her feel like a child.

Interview, on 04/02/14 at 8:55 AM, with CNA #7 revealed she indicated she had been trained on the facility's abuse policy in orientation when she was hired. CNA #7 stated when she worked the nightshift on 03/06/14, Resident #1 had rang the call light numerous times and banged the call light on the bedside table to request pain medication. CNA #7 reported she was at the nurse's station, multiple rooms away from Resident #1's room, and hear the nurse being very loud and she stated she could hear banging on the table. The CNA stated she heard the nurse tell Resident #1 he/she would not get his/her medication any quicker by banging on the table. CNA #7 indicated she should have reported what had happened immediately per the facility's policy; however, she was scared the nurse would find out she had reported it. CNA #7 did not report the incident until 03/09/14, three (3)

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5. The Administrator will bring trends identified from the daily review of allegations, complaints and grievances, and employee and resident interviews to the monthly Quality Assurance /Performance Improvement Committee x4 months for further review and recommendations.
6. Completion date 5/1/14.

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F 226 | Continued From page 67 days later.

Interview with CNA #3 on 04/02/14 at 8:55 AM and 04/09/14 at 6:58 PM, revealed she indicated she had been trained on the facility's abuse policy on hire. CNA #3 stated she worked nightshift on 03/06/14, and Resident #1 had used his/her call light frequently to request pain medication. She stated the nurse had been on break and when the nurse returned she told her Resident #1 needed pain medication. CNA #3 reported she later overheard LPN #6 at the nurse's station telling other staff she had informed Resident #1 by banging the call light he/she was acting like a child. CNA #3 stated the nurse should not have called Resident #1 a child and thought the incident was mental or verbal abuse. However, she had not reported the incident as per the facility's policy, but probably should have. CNA #3 indicated if abuse was suspected it was supposed to be reported immediately as per the policy.

Interview, on 04/10/14 at 3:54 PM, with RN #4/Weekend Supervisor revealed on 03/09/14 at approximately 8:00 PM, a nurse told her about an incident involving Resident #1 and she had gone and talked to the resident. RN #4/Weekend Supervisor reported Resident #1 told her he/she had banged the call light on the table to get attention as he/she wanted a pain pill as he/she was in pain. The RN stated Resident #1 told her LPN #6 had screamed at him/her and told him/her by making that noise he/she was annoying other residents. She stated she also talked to CNA #7, who had worked at the time of the incident, and CNA #7 told her the nurse had yelled so loudly at Resident #1 she could be heard at the nurse's station. RN #4/Weekend

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F 226	Continued From page 68  Supervisor stated she asked CNA #7 why she had not reported the incident when it occurred and the CNA indicated she was afraid the nurse would be mad at her. The RN indicated CNA #7 should have reported the alleged abuse immediately and so should any other staff who had knowledge of the incident as that was the facility's policy. RN#4/Weekend Supervisor stated she called the DNS who told her LPN #6 could not work and the LPN did not work. She indicated the DNS came in and took Resident #1's written statement.  Interview, on 04/03/14 at 12:38 PM, with Registered Nurse (RN) #3/300 Unit Manager, where Resident #1 resided, revealed she found about the incident on 03/10/14. She indicated staff should have reported the incident immediately as this was the facility's policy.  Interview with Social Worker (SW) #1 on 04/01/14 at 5:54 PM, revealed she had discussed the incident with Resident #1 on 03/17/14, and from what the resident described had happened she would consider the nurse's actions as abuse. SW #1 indicated if staff was aware of the incident it should have been reported immediately to the supervisor as per the facility policy.  Interview with the DNS on 04/02/14 at 12:30 PM and on 04/04/14 at 5:00 PM, revealed she was not aware of the incident until evening shift on 03/09/14, and she started an investigation at that time. The DNS stated the facility's investigation had determined staff who had witnessed the incident had not followed the facility policy and reported the alleged abuse immediately. She reported staff who had knowledge of the incident did not report it because of concern over	F 226			

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F 226	<p>Continued From page 69</p> <p>reporting the nurse involved. The DNS indicated if the alleged abuse had been reported immediately an investigation could have been initiated at that time and the nurse suspended. She stated the facility's expectation was for staff to report immediately to their supervisor if they became aware of an abuse allegation.</p> <p>interview, on 04/02/14 at 1:53 PM and on 04/03/14 at 6:46 PM, with the Administrator revealed she indicated her expectation was for any suspected abuse staff should report it immediately to their supervisor and the supervisor was to call her or her designee as per the policy. She stated it was important allegations were investigated to ensure if it involved a staff person, the person was taken out of the equation. She stated the investigation process included asking the person who reported it what happened, talking to the resident involved and collecting witness statements from other residents and staff, depending on what the allegation concerned to ensure resident safety. The Administrator indicated when abuse was reported the facility was to report it to the State Agencies, do the investigation and report the results to the State Survey Agency as per the policy. However, the facility failed to follow the policies and procedures to investigate and protect residents related to the incident involving Resident #1 and Resident #2.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 04/08/14 which alleged removal of the Immediate Jeopardy (IJ) effective 04/07/14. Review of the AOC revealed the facility had implemented the following:</p> <p>1. The facility's DNS, Administrator and Nurse</p>	F 226		

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F 226	Continued From page 70 Supervisors interviewed all interviewable residents to determine if they had experienced or witnessed any abuse in the facility or any issues with receiving PRN medications timely or threatening to have their medication withheld. The facility completed the interviews 03/14/14 and on 04/04/14.  2. The facility's DNS and Nurse Supervisors completed assessments of all non-interviewable residents to determine any injury associated with possible abuse. The facility completed the assessments on 03/14/14 and on 04/04/14.  3. The DNS and Administrator were re-educated to the Abuse Policy, the timely reporting requirements and completion of a thorough investigation by the MCO on 03/12/14 and on 04/03/14.  4. The facility's DNS, Administrator and Nurse Supervisors educated administrative, therapy, dietary, housekeeping, laundry, and maintenance staff on the facility's abuse policy, reporting requirements, promise of confidentiality, and no fear of retribution. Staff was also inserviced on stress management. Employees completed the Abuse Prevention post-test. The facility completed the inservices on 03/14/14 and again on 04/04/14.  5. The facility's DNS and Nurse Supervisors educated licensed nurses to count off controlled medications and relinquish med cart keys with another nurse if leaving the facility for lunch breaks or other periods of time to ensure medications were accessible to administer to residents as needed. The facility completed the inservices on 03/14/14.	F 226			

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F 226	<p>Continued From page 71</p> <p>6. The facility's DNS and Administrator were responsible for terminating the nurse involved in the allegation of abuse for Resident #1 and reporting the nurse to the Kentucky Board of Nursing. The facility completed the action on 03/14/14.</p> <p>7. The two (2) staff members who heard the incident involving Resident #1, but did not report the allegation received disciplinary action by the DNS and Administrator. The facility completed the action on 03/14/14.</p> <p>8. A Performance Improvement (PI) Meeting, to include the Administrator, DNS and Medical Director was held to discuss the late reporting of the allegation of abuse related to Resident #1 and the plan to correct this. The facility completed this action on 03/14/14.</p> <p>Additionally, a Performance Improvement Meeting, to include the Administrator, DNS and Medical Director, was held to discuss the late reporting of the allegation of abuse related to Resident #2, the Immediate Jeopardy citations, root cause and plan of correction. The facility completed this on 04/04/14.</p> <p>9. The nurse identified in the allegation of abuse for Resident #2 was suspended on 04/03/14. The facility identified the DNS and Administrator as being responsible for the action. The facility completed the action on 04/03/14.</p> <p>10. The initial report of the allegation involving Resident #2 was submitted to the State Agencies on 04/03/14, the persons assigned responsibility were the DNS and Administrator. The facility</p>	F 226		
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F 226	<p>Continued From page 72 completed the action on 04/03/14.</p> <p>11. The facility's DNS and Administrator was responsible for interviewing Resident #2 regarding the allegation of abuse reported on 03/02/14. The facility completed the action on 04/04/14.</p> <p>12. The facility's DNS, Administrator and Nursing Supervisors were responsible for interviewing the sister of Resident #2 regarding the allegation of abuse reported on 03/02/14. The facility completed the action on 04/04/14.</p> <p>13. The facility's DNS, Administrator and Nurse Supervisors were responsible for interviewing employees who worked 7:00 AM to 3:00 PM on 03/02/14 regarding the allegation of abuse related to Resident #2. The facility completed the interviews on 04/05/14.</p> <p>14. The facility's DNS and Nurse Supervisors were responsible to enter the allegation of abuse for Resident #2 into the Risk Management System (RMS). The facility completed the action on 04/04/14.</p> <p>15. The facility's DNS, Nurse Supervisors and Administrator were responsible to provide education to new hires on the facility's abuse policy, reporting requirements, promise of confidentiality, and no fear of retribution during orientation. This was an ongoing action. The facility did not use agency staff.</p> <p>16. The facility was to assign supervisors on each shift to monitor staff and resident interactions and to determine any allegations of abuse were reported immediately to the Administrator. The</p>	F 226		

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F 226	<p>Continued From page 73</p> <p>facility's Administrator and DNS were responsible to implement the action and the facility completed on 04/04/14.</p> <p>17. The facility was to implement monitoring actions to include interview of five (5) employees weekly for four (4) weeks and then monthly for three (3) months to determine: staff understood the facility's abuse policy; understood reporting allegations to the Administrator immediately; and understood allegations or statements were kept confidential and there was no fear of retribution for reporting. Any concerns were to be addressed at the time of interview. The facility identified the DNS, Nurse Supervisors and Administrator as being responsible for the audits which were ongoing.</p> <p>18. The facility was to implement monitoring actions to include interview of five (5) residents weekly for four (4) weeks and then monthly for three (3) months to determine any issues with staff treatment or abuse and any issues with withholding of medication. Any concerns identified were to be addressed at that time. The facility identified the Administrator as being responsible for he audits and they were ongoing.</p> <p>19. The facility was to implement monitoring actions to include an audit of all abuse investigations to determine that abuse allegations were reported timely as per the abuse policy and the investigations were thoroughly completed. Any concerns identified during the audit were to be addressed at that time. The facility identified the Administrator as being responsible for the audits and they were to be ongoing.</p> <p>20. The findings of the monitoring identified</p>	F 226		

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F 228	Continued From page 74 above were to be reported to the Performance Improvement Committee monthly for four (4) months for further review and recommendation. The Administrator and DNS were responsible and this was to be ongoing.  21. The facility was to perform an audit on abuse allegations identified for the prior thirty (30) days, 03/06/14 through 04/06/14, to assure a thorough investigation was completed and any abuse was reported timely as per the facility policy. The person responsible was the MCO and the facility was to complete this on 04/07/14.  The State Survey Agency validated the implementation of the facility's AOC as follows:  1. Interview and review of the facility's AOC implementation documentation for Resident #1 and Resident #2, with the DNS on 04/10/14 at 10:37 AM, 12:13 PM and at 1:16 PM, revealed the facility used a Resident Census Report to identify all interviewable residents. The resident interviews were performed by the DNS and Nursing Supervisors which included Unit Managers. Reviewed the documented resident interviews all completed by 03/14/14 and 04/04/14.  Interview with the Assistant Director of Nursing (ADON) on 04/10/14 at 4:27 PM, and RN #5/100 Unit Manager on 04/10/14 at 4:48 PM revealed resident interviews were performed as per the AOC.  Interview on 04/10/14, with Resident #1 at 12:58 PM; Resident #2 at 10:19 AM; Unsampeld Resident A at 5:05 PM; Unsampeld Resident B at 4:49 PM; and Unsampeld Resident C at 5:10 PM	F 228		
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F 226	<p>Continued From page 75</p> <p>revealed they were all interviewed by facility staff two (2) different times recently about abuse and medications.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she was in charge of the AOC plan to make sure everything was completed as indicated and verified all the resident interviews were completed by the 03/14/14 and 04/04/14 as noted on the AOC.</p> <p>2. Interview and review of the facility's AOC implementation documentation with the DNS on 04/10/14 at 10:37 AM, 12:13 PM and at 1:16 PM, revealed the facility used a Resident Census Report to identify all non-interviewable residents. The DNS stated they had two (2) staff present for skin assessments and no problems were identified indicating abuse, such as, bruises, scratches, any type of redness or any signs they were not getting care. Review and interview with the DNS revealed the skin assessments were performed by the DNS and Nursing Supervisors on 03/13/14, 03/14/14 and again on 04/04/14 with no issues identified.</p> <p>Interview with the ADCN on 04/10/14 at 4:27 PM and RN #5/100 Unit Manager at 4:48 PM, revealed skin assessments were performed on non-interviewable residents.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she had verified all skin assessments of non-interviewable residents were completed by 03/14/14 and 04/05/14 as noted on the AOC with no issues identified.</p> <p>3. Review of a documented inservice on 03/12/14 and 04/03/14 revealed the DNS and Administrator</p>	F 226		

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F 226	<p>Continued From page 76</p> <p>were re-educated on the facility's abuse policy and reporting requirements by the MCO.</p> <p>Interview with the DNS on 04/10/14 at 12:13 PM, and the Administrator on 04/10/14 at 5:29 PM, revealed both had received an inservice on the abuse policy and reporting requirements on 03/12/14 and 04/03/14 by the MCO.</p> <p>4. Interview and review of the facility's AOC implementation documentation for Resident #1 and Resident #2, with the DNS on 04/10/14 at 10:37 AM, at 12:13 PM and at 1:16 PM, revealed the facility used a master list of employees to inservice all staff on 03/10/14 thru 03/14/14 and on 04/03/14 thru 04/04/14. The DNS stated staff inservices included review of the abuse policy which included examples of abuse and reporting, investigations and reporting were confidential, stress management, and abuse post-test. She further stated inservices were performed by the Administrative team which included herself, the Administrator and Nursing Supervisors. The DNS stated staff who were not present were contacted by phone and given the inservice on the abuse policy and stress management. She indicated staff who the facility was unable to contact by phone were sent the inservice education by certified mail. The list of staff who were sent the inservice education by certified mail and the certified mail receipts were reviewed. Interview with the DNS revealed when the staff who were not present at the inservice came in to work they went over the post test and signed inservice sheets prior to beginning work. She stated the inservices were performed by the Administrative team which included herself, the Administrator and Nursing Supervisors.</p>	F 226		
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F 226	<p>Continued From page 77</p> <p>Review of the AOC implementation documentation revealed a master list of employees which showed staff were inserviced from 03/10/14 through 03/14/14 and on 04/03/14 and 04/04/14, on the abuse policy, reporting requirements, promise of confidentiality, no fear of retribution and stress management. The inservice material and post-tests completed by employees after the inservicing were reviewed.</p> <p>Interview on 04/10/14 with the ADON at 4:27 PM; RN #4/Weekend Supervisor at 4:08 PM; Activities Director at 2:44 PM; the Employee Benefits and Payroll Coordinator at 3:13 PM; the Maintenance Director at 3:39 PM; and RN #5/100 Unit Manager at 4:48 PM revealed they had inserviced staff on the facility's abuse policy and stress management in March and April.</p> <p>Staff interviews on 04/09/14 with LPN #10 at 5:22 PM; CNA #18 at 5:30 PM; LPN #11 at 5:41 PM; CNA #14 at 5:51 PM; CNA #3 at 6:55 PM; and, on 04/10/14 with LPN #12 at 7:30 AM; LPN # 13 at 7:50 AM; LPN # 14 at 7:55 AM; Dietary Aide #1 at 2:05 PM; Housekeeping #1 at 2:18 PM; Dietary Aide #2 at 2:27 PM; Housekeeping #2 at 2:32 PM; Activities Director at 2:44 PM; Maintenance #1 at 2:55 PM; Laundry #1 at 3:04 PM; Employee Payroll and Benefits Coordinator at 3:13 PM; Occupation Therapist (OT) #1 at 3:21 PM; Physical Therapy Assistant (PTA) #1 at 3:26 PM; CNA #16 at 3:33 PM; Maintenance #2 at 3:39 PM; CNA #17 at 3:47 PM; RN #4/Weekend Supervisor at 4:08 PM; and LPN #15 at 4:17 PM revealed all indicated they had received inservices on abuse in March and April which included the types of abuse, how and when to report abuse, confidentiality/retribution, and stress management.</p>	F 226		
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F 226	Continued From page 78  5. Interview and review of the facility's AOC implementation documentation for Resident #1, with the DNS on 04/10/14 at 12:13 PM and at 1:16 PM, revealed the facility used a master list of nurses identified as receiving inservice education on 03/13/14 and 03/14/14 on counting controlled medications in the medication carts and giving the medication cart keys to another nurse before leaving the facility for lunch breaks. She stated the inservices were performed by herself and the Nursing Supervisors.  Interview on 04/10/14 with DNS and ADON at 4:27 PM, RN #4/Weekend Supervisor at 4:08 PM, Activities Director at 2:44 PM, and RN #5/Unit Manager 100 at 4:48 PM revealed they inserviced staff on abuse in March and when applicable nursing staff on med cart.  Staff interviews on 04/09/14 with LPN #10 at 5:22 PM; LPN #11 at 5:41 PM; and on 04/10/14 with LPN #12 at 7:30 AM; LPN #13 at 7:50 AM; LPN #14 at 7:55 AM; RN #4/Weekend Supervisor at 4:08 PM; and LPN #15 at 4:17 PM revealed all indicated they had received inservices on counting controlled medications in the medication carts and on giving the medication cart keys to another nurse prior to leaving the facility for lunch breaks in March.  Interview with the Administrator, on 04/10/14 at 5:29 PM, revealed nurses were inserviced staff as indicated on the AOC in March.  6. Review of the facility's report of LPN #6 to KBN revealed the nurse was reported on 03/21/14. Personnel record review revealed LPN #6 was terminated from employment.	F 226			

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F 226	Continued From page 79  Interview with the DNS on 04/10/14 at 1:16 PM and the Administrator at 5:29 PM, revealed LPN #6 was terminated on 03/17/14 per the AOC and reported to KBN by the DNS.  7. Interview with the DNS on 04/10/14 at 1:16 PM and the Administrator at 5:29 PM, revealed the two (2) staff who did not report the abuse of Resident #1 received final written warnings by the DNS for not reporting timely. The final written warnings for CNA #3 and CNA #7 were reviewed.  Interview with CNA #7 on 04/02/14 at 8:55 AM and CNA #3 on 04/09/14 at 6:58 PM, revealed they were counseled by the facility about reporting abuse sooner.  8. Review of the PI meeting sign in sheets dated 03/14/14 and 04/04/14, revealed it was signed by Administrator, DNS and Medical Director.  Interview with the Medical Director on 04/09/14 at 4:13 PM, revealed he attended the PI meeting in March about the allegation of abuse involving Resident #1 and a nurse. He stated they discussed what happened and an action plan on how to prevent it from happening again. Additionally, the Medical Director stated he attended the PI meeting in April regarding the allegation of abuse involving Resident #2 and in the meeting they had discussed the Immediate Jeopardy related to the abuse incident and the action plan to prevent reoccurrence.  Interview with the DNS on 04/10/14 at 12:13 PM and the Administrator at 5:29 PM, revealed they attended the March and April PI meeting with the Medical Director and discussed the allegation of	F 226		