

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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

AMENDED

An Abbreviated Survey investigating KY#00019744 was initiated on 02/06/13 and concluded on 02/08/13. KY#00019744 was substantiated with deficient practice identified.

F 226 483.13(c) DEVELOP/IMPLMENT
SS=D 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, review of the investigative report and review of the facility's policy, it was determined the facility failed to implement policies and procedures related to preventing further potential abuse when Housekeeper #1 failed to report an allegation of abuse immediately to a supervisor on 01/25/13. Housekeeper #1 alleged State Registered Nursing Assistant (SRNA) #5 cursed and yelled at Resident #35 while pulling Resident #35 down a hallway backwards in his/her wheelchair, on the evening of 01/25/13. Housekeeper #2 did not report the incident to LPN #3 until 01/31/13, six (6) days later. SRNA #5 provided care to residents the rest of her shift on 01/25/13 and also provided care to residents on 01/28/13, 01/29/13 and 01/30/13.

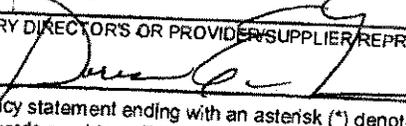
F 000

Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.

F 226

2/15/13

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FEB 27 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X6) DATE 2/27/2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226 Continued From page 1

The findings include:

Review of the facility's policy titled 'Abuse, Neglect, or Misappropriation of Resident Property', dated 02/2009, revealed any employee who witnesses or suspects that abuse, neglect, or misappropriation of of property has occurred would immediately report the alleged incident to their supervisor, who would immediately report the incident to the Administrator. Further review of the policy revealed measures would be initiated to prevent any further potential abuse while the investigation was in progress. Continued review of the policy revealed employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property would be suspended immediately from duty pending the outcome of the investigation.

Review of the medical record revealed the facility admitted Resident #35 on 11/18/10, with diagnoses which included Abnormality of Gait, Depressive Disorder, Dementia with Behavior Disturbances. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 12/03/12, revealed the facility assessed Resident #35 to have a Brief Interview for Mental Status (BIMS) score of three out of fifteen (3/15) indicating Resident #35 was cognitively impaired. Further review of the MDS revealed the facility assessed Resident #35 to need extensive assistance of two (2) for transfers, extensive assistance of one (1) for ambulation, utilized a wheelchair, was resistive to care, and had verbal and physical aggression. During an attempted interview, on 02/07/13 at 10:20 AM, Resident #35 did not respond to any questions related to care and

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F 226
The allegation of abuse to Resident #35 was not substantiated as reported. Resident #35 is not interviewable with a BIMS score of 3. Housekeeper #1 was provided one-on-one education regarding reporting of allegation of abuse by Staff Facilitator on 1/31/2013. Her competency was validated by a post test on 2/14/2013. SRNA #5 was educated by the DON on 2/1/2013 regarding the when a resident is unable to be redirected and uncooperative is to take the time to approach the resident in a manner not to further irritate them or call for assistance from other staff.

The policy, "Abuse, Neglect, or Misappropriation of Resident Property" was reviewed by the Administrator on 2/8/2013 and determined to require no revision to meet the intent of this regulation as

it addresses the seven components.

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F 226 Continued From page 2
services or staff treatment of the resident.

Review of the facility's initial report of abuse allegation, dated 01/31/13, and the final abuse investigation, dated 02/04/13, revealed on 01/31/13 Housekeeper #1 reported to Licensed Practical Nurse (LPN) #3 that on the evening she worked the second shift she saw a staff mistreat Resident #35. It stated Housekeeper #1 had worked the evening of 01/25/13 and alleged SRNA #5 told Resident #35 to "get the hell out of the way". Housekeeper #1 alleged SRNA #5 moved Resident #35 back and then took the arm of the resident's wheelchair and proceeded to "drag" Resident #35 down the hallway towards the South Nurse's Station as Resident #35 cussed ARNA #5 when they went down the hallway. The report revealed the facility was unable to substantiate the complaint as abuse as SRNA #5 denied being verbally abusive towards Resident #35. The report indicated SRNA #5 asked Resident #35 to move out of the way and he/she refused by stating "I don't have to get the hell out of the way" and she pulled Resident #35 in his/her wheelchair as she pulled a food cart in order to ensure the resident was safely out of the way. Review of the investigative report revealed SRNA #5 was interviewed about the incident on 02/01/13 prior to the start of her shift at 2:00 PM and was allowed to work.

Review of SRNA #5's timecard revealed SRNA #5 worked the rest of her shift on 01/25/13, 2:00 PM until 10:00 PM on 01/28/13 and 01/29/13 and 6:00 AM until 10:00 PM on 01/30/13.

Interview with Housekeeper #1, on 02/08/13 at 10:15 AM, revealed on 01/25/13 at approximately

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The competency level of all staff, including Housekeeper #1, with regard to understanding the policy "Abuse, Neglect, or Misappropriation of Resident Property" including timely reporting of any allegation of abuse or neglect was validated by the Administrator and Staff Facilitator on 2/11/2013 through 2/14/2013. This was done through the use of an Abuse Questionnaire.

All new employees are provided education with regard to the policy "Abuse, Neglect, or Misappropriation of Resident Property" including protecting the resident and timely reporting to proper authorities during orientation.

All residents have the potential to be affected.

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F 226 Continued From page 3
5:30 PM she heard SRNA #5 yell at Resident #35 to "get the hell out of the way". She indicated when Resident #35 would not get out of the way that SRNA #5 took the back of Resident #35's wheelchair and pulled him/her backwards down the hall past the dining room. Housekeeper #1 stated SRNA #5 and Resident #35 kept cursing each other back and forth as SRNA #5 pulled Resident #35 down the hall. Housekeeper #1 stated she did not report the incident to anyone until 01/31/13 (six days later) because State Registered Nurse Aide (SRNA) #3 was in the dining room at that time and she thought she would have reported it. Continued interview revealed she had received an individualized training on 01/31/13 by LPN #3 about abuse and indicated she was told she had up to twenty-four (24) hours to report abuse allegations. She stated she had received an in-service training recently by the Housekeeping Director and indicated he had said she had up to twenty-four (24) hours to report abuse allegations.

Interview with SRNA #3, on 02/08/13 at 1:00 PM, revealed she did not hear or see the alleged incident from 01/25/13. Further interview revealed Resident #35 had a history of cursing and spoke loudly and from where she was sitting in the dining room, she would have heard it and would have reported the incident immediately.

During an interview with LPN #2, on 02/08/13 at 11:00 AM, SRNA #5 indicated when Resident #35 would not move out of the way of the food cart and he/she cursed at her so she took the arm of the wheelchair and pulled it along with Resident #35 approximately five (5) to ten (10) feet forward with one hand while pulling the food cart with the

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To ensure that all resident concerns and/or allegations are reported to the appropriate agencies timely, the Administrator will interview residents and staff during administrative rounds conducted daily Monday – Friday by the Administrator to identify any concerns that have not been reported. Staff knowledge will be validated through the use of the Abuse Questionnaire. The Administrator and/or the Staff Facilitator will randomly select 10% of the staff each month who will complete the Abuse Questionnaire; once selected, staff will not be eligible to be selected again for 90 days.

The results of the administrative rounds and validation questionnaires

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F 226 Continued From page 4
other to make sure Resident #35 was safely out of the way. Additional interview revealed Resident #35 had a history of being verbally abusive towards others and that when she asked him/her to move out of the way he/she stated he/she "did not have to move the hell out of the way".

Interview with the Housekeeping Director, on 02/08/13 at 4:00 PM, revealed he had conducted an in-service training with all the housekeeping staff, on 02/04/13 after the facility realized Housekeeper #1 had not reported the incident immediately. Additional interview revealed he informed his staff they had to report allegations of abuse immediately so "we" could report to the State Agency within twenty-four (24) hours. Further interview revealed he thought maybe some staff had misunderstood him when he said "we" (meaning facility management staff) and they thought they had up to twenty-four (24) hours to report. Continued interview revealed he had randomly given a quiz to staff after the in-service on 02/04/13, but he had not had the opportunity to look at the quizzes to ensure staff was knowledgeable of when to report an abuse allegation. Continued interview revealed Housekeeper #1 was a little hard of hearing and he felt like she heard the resident say "get the hell out of the way" and thought it was the staff member who had stated that.

Review of the housekeeping abuse quiz, no date, revealed Housekeeper #1 answered the question of when to report abuse by documenting two answers; immediately and no later than twenty-four (24) hours.

Interview with the Administrator, on 02/08/13 at

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will be reported monthly for the next three months, then quarterly thereafter, until we have three consecutive quarters of no identified issues, to the Quality Improvement Executive Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, QI Nurse and any other persons required to provide information pertinent to the reports being presented and discussed at the Executive Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy or other course of action based upon the data presented.

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F 226	Continued From page 5 4:20 PM, revealed staff was supposed to report allegations of abuse to their supervisor or if the supervisor was not at the facility to a charge nurse immediately. Additional interview revealed she had in-serviced and in-serviced and in-serviced staff related to reporting abuse and although not always documented she randomly asked staff questions related to recognizing and reporting abuse.	F 226		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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N 000	INITIAL COMMENTS AMENDED A Complaint Survey investigating KY#00019744 was initiated on 02/06/13 and concluded on 02/08/13. Complaint KY#00019744 was substantiated with deficient practice identified.	N 000		
N 105	902 KAR 20:300-5(3) Section 5. Resident Behavior & Fac. Practice (3) Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents. This requirement is not met as evidenced by: Based on interview, record review, review of the investigative report and review of the facility's policy, it was determined the facility failed to implement policies and procedures related to preventing further potential abuse when Housekeeper #1 failed to report an allegation of abuse immediately to a supervisor on 01/25/13. Housekeeper #1 alleged State Registered Nursing Assistant (SRNA) #5 cursed and yelled at Resident #35 while pulling Resident #35 down a hallway backwards in his/her wheelchair, on the evening of 01/25/13. Housekeeper #2 did not report the incident to LPN #3 until 01/31/13, six (6) days later. SRNA #5 provided care to residents the rest of her shift on 01/25/13 and also provided care to residents on 01/28/13, 01/29/13 and 01/30/13. The findings include: Review of the facility's policy titled 'Abuse, Neglect, or Misappropriation of Resident Property' dated 02/2009, revealed any employee	N 105	Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. N105 The allegation of abuse to Resident #35 was not substantiated as reported. Resident #35 is not interviewable with a BIMS score of 3. Housekeeper #1 was provided one-on-one education regarding reporting of allegation of abuse by Staff	2/15/13

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STATE FORM

TITLE
Admin

(X6) DATE
2/27/2013

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N 105	Continued From page 1 who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred would immediately report the alleged incident to their supervisor, who would immediately report the incident to the Administrator. Further review of the policy revealed measures would be initiated to prevent any further potential abuse while the investigation was in progress. Continued review of the policy revealed employees accused of being directly involved in allegations of abuse, neglect, or misappropriation of property would be suspended immediately from duty pending the outcome of the investigation. Review of the medical record revealed the facility admitted Resident #35 on 11/18/10, with diagnoses which included Abnormality of Gait, Depressive Disorder, Dementia with Behavior Disturbances. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 12/03/12, revealed the facility assessed Resident #35 to have a Brief Interview for Mental Status (BIMS) score of three out of fifteen (3/15) indicating Resident #35 was cognitively impaired. Further review of the MDS revealed the facility assessed Resident #35 to need extensive assistance of two (2) for transfers, extensive assistance of one (1) for ambulation, utilized a wheelchair, was resistive to care, and had verbal and physical aggression. During an attempted interview, on 02/07/13 at 10:20 AM, Resident #35 did not respond to any questions related to care and services or staff treatment of the resident. Review of the facility's initial report of abuse allegation, dated 01/31/13, and the final abuse investigation, dated 02/04/13, revealed on 01/31/13 Housekeeper #1 reported to Licensed Practical Nurse (LPN) #3 that on the evening she worked the second shift she saw a staff mistreat	N 105	Facilitator on 1/31/2013. Her competency was validated by a post test on 2/14/2013. SRNA #5 was educated by the DON on 2/1/2013 regarding the when a resident is unable to be redirected and uncooperative is to take the time to approach the resident in a manner not to further irritate them or call for assistance from other staff. The policy, "Abuse, Neglect, or Misappropriation of Resident Property" was reviewed by the Administrator on 2/8/2013 and determined to require no revision to meet the intent of this regulation as it addresses the seven components. The competency level of all staff, including Housekeeper #1, with regard to understanding the policy "Abuse, Neglect, or Misappropriation of Resident Property" including timely reporting of any allegation of abuse or neglect was validated by the Administrator and Staff Facilitator on 2/11/2013 through 2/14/2013. This was done through the use of an Abuse Questionnaire.	

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N 105	Continued From page 2 Resident #35. It stated Housekeeper #1 had worked the evening of 01/25/13 and alleged SRNA #5 told Resident #35 to "get the hell out of the way". Housekeeper #1 alleged SRNA #5 moved Resident #35 back and then took the arm of the resident's wheelchair and proceeded to "drag" Resident #35 down the hallway towards the South Nurse's Station as Resident #35 cussed ARNA #5 when they went down the hallway. The report revealed the facility was unable to substantiate the complaint as abuse as SRNA #5 denied being verbally abusive towards Resident #35. The report indicated SRNA #5 asked Resident #35 to move out of the way and he/she refused by stating "I don't have to get the hell out of the way" and she pulled Resident #35 in his/her wheelchair as she pulled a food cart in order to ensure the resident was safely out of the way. Review of the investigative report revealed SRNA #5 was interviewed about the incident on 02/01/13 prior to the start of her shift at 2:00 PM and was allowed to work. Review of SRNA #5's timecard revealed SRNA #5 worked the rest of her shift on 01/25/13, 2:00 PM until 10:00 PM on 01/28/13 and 01/29/13 and 6:00 AM until 10:00 PM on 01/30/13. Interview with Housekeeper #1, on 02/08/13 at 10:15 AM, revealed on 01/25/13 at approximately 5:30 PM she heard SRNA #5 yell at Resident #35 to "get the hell out of the way". She indicated when Resident #35 would not get out of the way that SRNA #5 took the back of Resident #35's wheelchair and pulled him/her backwards down the hall past the dining room. Housekeeper #1 stated SRNA #5 and Resident #35 kept cursing each other back and forth as SRNA #5 pulled Resident #35 down the hall. Housekeeper #1 stated she did not report the incident to anyone	N 105	All new employees are provided education with regard to the policy "Abuse, Neglect, or Misappropriation of Resident Property" including protecting the resident and timely reporting to proper authorities during orientation. To ensure that all resident concerns and/or allegations are reported to the appropriate agencies timely, the Administrator will interview residents and staff during administrative rounds conducted daily Monday - Friday by the Administrator to identify any concerns that have not been reported. Staff knowledge will be validated through the use of the Abuse Questionnaire. The Administrator and/or the Staff Facilitator will randomly select 10% of the staff each month who will complete the Abuse Questionnaire; once selected, staff will not be eligible to be selected again for 90 days.		

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N 105	<p>Continued From page 3</p> <p>until 01/31/13 (six days later) because State Registered Nurse Aide (SRNA) #3 was in the dining room at that time and she thought she would have reported it. Continued interview revealed she had received an individualized training on 01/31/13 by LPN #3 about abuse and indicated she was told she had up to twenty-four (24) hours to report abuse allegations. She stated she had received an in-service training recently by the Housekeeping Director and indicated he had said she had up to twenty-four (24) hours to report abuse allegations.</p> <p>Interview with SRNA #3, on 02/08/13 at 1:00 PM, revealed she did not hear or see the alleged incident from 01/25/13. Further interview revealed Resident #35 had a history of cursing and spoke loudly and from where she was sitting in the dining room, she would have heard it and would have reported the incident immediately.</p> <p>During an interview with LPN #2, on 02/08/13 at 11:00 AM, SRNA #5 indicated when Resident #35 would not move out of the way of the food cart and he/she cursed at her so she took the arm of the wheelchair and pulled it along with Resident #35 approximately five (5) to ten (10) feet forward with one hand while pulling the food cart with the other to make sure Resident #35 was safely out of the way. Additional interview revealed Resident #35 had a history of being verbally abusive towards others and that when she asked him/her to move out of the way he/she stated he/she "did not have to move the hell out of the way".</p> <p>Interview with the Housekeeping Director, on 02/08/13 at 4:00 PM, revealed he had conducted an in-service training with all the housekeeping staff, on 02/04/13 after the facility realized Housekeeper #1 had not reported the incident</p>	N 105	<p>The results of the administrative rounds and validation questionnaires will be reported monthly for the next three months, then quarterly thereafter, until we have three consecutive quarters of no identified issues, to the Quality Improvement Executive Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, QI Nurse and any other persons required to provide information pertinent to the reports being presented and discussed at the Executive Committee meeting. The Executive QI Committee will make recommendations for further action such as more staff education, change in process, procedure or policy or other course of action based upon the data presented.</p>	

PRINTED: 02/27/2013
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 105	Continued From page 4 immediately. Additional interview revealed he informed his staff they had to report allegations of abuse immediately so "we" could report to the State Agency within twenty-four (24) hours. Further interview revealed he thought maybe some staff had misunderstood him when he said "we" (meaning facility management staff) and they thought they had up to twenty-four (24) hours to report. Continued interview revealed he had randomly given a quiz to staff after the in-service on 02/04/13, but he had not had the opportunity to look at the quizzes to ensure staff was knowledgeable of when to report an abuse allegation. Continued interview revealed Housekeeper #1 was a little hard of hearing and he felt like she heard the resident say "get the hell out of the way" and thought it was the staff member who had stated that. Review of the housekeeping abuse quiz, no date, revealed Housekeeper #1 answered the question of when to report abuse by documenting two answers; immediately and no later than twenty-four (24) hours. Interview with the Administrator, on 02/08/13 at 4:20 PM, revealed staff was supposed to report allegations of abuse to their supervisor or if the supervisor was not at the facility to a charge nurse immediately. Additional interview revealed she had in-serviced and in-serviced and in-serviced staff related to reporting abuse and although not always documented she randomly asked staff questions related to recognizing and reporting abuse.	N 105		