

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

PRINTED: 07/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/06/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018		
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F 226	<p>Continued From page 52</p> <p>revealed they all had attended the mandatory inservices related to abuse and Resident Rights. Those interviewed were able to explain their responsibilities if abuse were observed, reported or suspected. All interviewees were cross-checked to the education sign-in sheets and post-tests.</p> <p>8. Review of the facility's implementation documentation binder for the AOC revealed an ongoing investigation of a resident to resident altercation, which was not sexual in nature. Review of the investigation documentation revealed all required notifications were made timely in accordance with facility policy and federal and state regulations.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they would ensure notification of the State Survey Agency, Adult Protective Services, the Ombudsman and local law enforcement of all sexually aggressive behaviors as indicated in the AOC. However, they reported no incidents of sexually aggressive behaviors had occurred since the alleged date of compliance, 06/04/14.</p> <p>9. Review of the facility's implementation documentation binder for the AOC revealed education records included sign-in sheets for all education provided. Continued review revealed staff members were checked off from a master list of all employees in order for the facility to ensure every staff member received the education prior to returning to work. In addition, copies of completed post-tests were available for review and were cross-checked with the sign-in sheets. A review of educational offering agendas revealed all topics included in the AOC were</p>	F 226			

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F 226 Continued From page 53
provided. Further review revealed all education was completed prior to or on 06/03/14 as alleged.

F 226

Interview with the Administrator and the DON on 06/05/14 at 4:45 PM, revealed all the education was mandatory with records being maintained. Interview with the SDN, on 06/05/14 at 4:30 PM, revealed she tracked employee attendance via the sign-in sheets and the master list. She stated she tried to make the inservices interesting to maintain the learners' attention, and utilized post-tests to verify effectiveness of the education.

10. Interview with the Administrator and the DON on 06/06/14 at 1:30 PM, revealed the Administrator was responsible for the overall administration of the facility. He stated his goal was to ensure every resident was safe and staff were knowledgeable regarding providing care according to the written Care Plan. He further stated he had been closely involved with the DON throughout the development and implementation of the AOC, including the monitoring of data collected as part of the QA process. The Administrator stated he and the DON ensured the education was provided. He indicated the facility would continue to evaluate, assess and update residents' Care Plans to ensure all residents were safe from harm. Both the Administrator and the DON stated every action outlined in the AOC had been conducted as alleged.

11. Review of the facility's implementation documentation binder for the AOC revealed residents' behaviors were documented by staff every shift. Continued review revealed QA team members reviewed the collected data daily Monday through Friday.

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F 226	Continued From page 54 Interview with the DON revealed she reviewed all documented behaviors daily Monday through Friday to ensure the Care Plans were revised to include new interventions as indicated by the exhibited behavior. She stated the data is collected by her, the ADON, SDN, RN Unit Managers and RN Supervisors, with all behaviors reviewed by her.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policies, it was determined the facility failed to have an effective system to ensure the implementation of care plan interventions by facility staff for one (1) of ten (10) sampled residents (Resident #1). On 04/27/14, Resident #3 reported to staff Resident #1 had "touched" him/her under his/her clothes, which the resident indicated had happened on 04/26/14 and on another day. Resident #3 told staff he/she was afraid of Resident #1. Review of Resident #1's Comprehensive Care Plan revealed an intervention dated 04/28/14 for the resident to be checked on every fifteen (15) minutes. However, record review revealed no documented evidence the intervention was implemented on that date. Additionally, review of the fifteen (15) minute	F 282	1. Immediate Need Care Plan for Male Resident was in place reflecting interventions for protection of Female Resident #1 by Unit Manager and ADON on 4/28/14. However there is sporadic documented evidence that the Care Plan was followed. Licensed Nursing staff was in-serviced on the Immediate Need Plan of Care and Comprehensive Care Plan use in directing resident care. In-servicing conducted by Staff Development RN, ADON, DON or Administrator. In-service will include documentation required of the use of the interventions on those Care Plans completed by 7/3/14. 2. A 100% audit for accuracy and thoroughness of all Immediate Need Plan of Care and Comprehensive Care Plan used in directing resident care and documentation guidelines completed by DON, ADON, Staff Development RN, and RN Unit Managers by 7/3/14. 3. Licensed Nursing staff was in-		

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F 282 Continued From page 55

check sheets revealed undated sheets and incomplete documentation of the checks through 05/10/14, with no documented evidence of the checks on several days. As a result of the facility's failure to implement Resident #1's care plan intervention for 15 minute checks, other residents were not protected from potential abuse. On 05/10/14, a staff person observed Resident #1 "groping" Resident #2 between his/her legs. Resident #1 was then placed on one on one (1:1) supervision, the Physician was notified, and an order was received to send the resident to the emergency room (ER) for evaluation and treatment. Resident #1 was discharged and was not a resident of the facility during the survey. (Refer to F-223)

The facility's failure to have an effective system in place to ensure implementation of care plan interventions was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 05/28/14, and was determined to exist on 04/27/14. The facility was notified of the Immediate Jeopardy on 5/28/14.

The facility provide an acceptable credible Allegation of Compliance (AOC) on 06/05/14, with the facility alleging removal of the Immediate Jeopardy on 06/04/14. The State Agency validated, the Immediate Jeopardy was removed on 06/04/14 as alleged with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F-282 at a Scope and Severity of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program monitors to ensure residents' care plans are implemented.

The findings include:

F 282

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

serviced on the Immediate Need Plan of Care and Comprehensive Care Plan use in directing resident care. In-servicing conducted by Staff Development RN, ADON, DON or Administrator. In-service includes documentation required of the use of the interventions on those Care Plans. No agency in use at the facility. All new hires will be educated during general orientation by the Staff Development RN. QA Committee members will review all immediate need plan of care daily minimally 5 days a week for 30 days or additionally as necessary until 7/21/14, then one time weekly until 8/21/14 or as needed, then monthly thereafter or as needed sooner. Compressive care plans are reviewed as MDS assessments are completed and/or with any change in interventions necessary for resident care.

4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held

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F 282	Continued From page 56 Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed an individualized comprehensive care plan which included measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs was to be developed for each resident. Further review of the policy revealed each resident's care plan was designed to identify the professional services that were responsible for each element of care. Review of the facility's policy titled, "Abuse Resident to Resident", dated October 2012, revealed immediate action was to be taken in any occurrence of a resident to resident altercation with immediate interventions taken to prevent reoccurrence of the altercation. Review of Resident #1's medical record revealed the facility admitted the resident on 06/14/13, with diagnoses which included Confusion and Dementia with Behavior Disorder. Review of the 03/16/14, Quarterly Minimum Data Set (MDS) Assessment for Resident #1 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15), which indicated he/she was moderately cognitively impaired. Review of Resident #1's Comprehensive Care Plan initiated on 09/25/13, revealed a behavior care plan for threatening staff verbally, physically throwing items at other residents, threatening to shoot another resident and expressing agitation towards another resident. Interventions included: removing the resident from "common areas during times of unacceptable behavior"; one on one (1:1) as needed; giving emotional	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> monthly with the presence of the Medical Director Quarterly. Next meeting with Medical Director will be held in July. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director. 5. Date of Compliance:	7/7/14	

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F 282	Continued From page 57 support; explaining his/her behaviors were unacceptable; and reapproaching at a later time. Review of Resident #1's Comprehensive Care Plan, with a revision date of 01/08/14, revealed a problem onset of wandering, going into others rooms. Continued review of the wander risk care plan revealed a goal for the resident not to go into other resident rooms without permission by next review on 06/15/14 and interventions including provide cueing as to where his/her room is as needed, redirect resident out of others rooms as needed, monitor for changes in cognitive status and rule out medical concerns. Continued record review for Resident #1 revealed a "late entry" Nurse's Note, dated 04/27/14 at 2:21 PM, for an incident which occurred at 9:15 AM that morning. Review of the "late entry" Note revealed a resident reported Resident #1 made inappropriate advances at him/her. Continued review of the "late entry" Note revealed the other resident told staff Resident #1 had attempted to touch him/her under his/her clothes yesterday and on another day. Review of the facility's initial Incident Report dated 04/27/14, revealed it noted Resident #3 reported to a nurse Resident #1 had "touched" him/her on the leg under his/her clothes two (2) times, and he/she was "afraid" of Resident #1. Further review of the Incident Report revealed measures were implemented to keep Resident #1 under watch by staff during the investigation. Continued review of the "Immediate Need Plan of Care", which was part of Resident #1's Comprehensive Care Plan, revealed it was revised on 04/28/14, with measures which	F 282			

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F 282	<p>Continued From page 58</p> <p>included interventions to change Resident #1's Seroquel (an antipsychotic medication) to fifty (50) milligram (mg) PRN (as necessary) and for fifteen (15) minute checks.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 5/23/14 at 2:30 PM, revealed she was assigned Resident #1's care frequently, and had been told by the nurses at times to keep an "eye on" the resident. She stated she had worked on 04/27/14 and Resident #3 told her about Resident #1 touching his/her legs. However, CNA #1 indicated she had not seen fifteen (15) minutes check sheets for the resident and thought the nurses were completing those.</p> <p>Interview with CNA #2 on 05/23/14 at 2:50 PM, with CNA #3 on 05/29/14 at 4:45 PM and with CNA #4 on 05/29/14 at 7:15 PM revealed they indicated they were not aware Resident #1 had been put on fifteen (15) minute checks. They reported they had been told to watch Resident #1 and "keep an eye on" the resident by other CNAs.</p> <p>Interview with CNA #5 on 05/29/14 at 7:00 PM revealed she had been told by the Charge Nurse once to keep an "eye on" Resident #1 after an incident involving Resident #3. CNA #5 indicated she was aware Resident #1 was on fifteen (15) minute checks; however, was uncertain when the checks started, and the nurses were supposed to do the checks.</p> <p>However, interview with LPN #2 on 05/29/14 at 4:00 PM, revealed she was not aware an intervention to perform fifteen (15) minutes checks was on Resident #1's Comprehensive Care Plan, and did not know fifteen (15) minute checks were to be completed on Resident #1.</p>	F 282			

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F 282	Continued From page 59 Interview with Registered Nurse (RN) #1 on 05/23/14 at 3:30 PM revealed she was unaware Resident #1 had sexual behaviors towards other residents and was unaware the resident was care planned for fifteen (15) minute checks. RN #1 commented she "just thought" Resident #1 had behaviors; however, not sexual behaviors towards other residents. She stated she "usually" just looked at residents' care plans for "lifts and transfers". Interview, on 05/27/14 at 10:00 AM with RN #2, Charge Nurse on the unit on which Resident #1 resided, revealed she was unaware Resident #1 was care planned for fifteen (15) minute checks after the 04/27/14 incident. She stated she was uncertain if the fifteen (15) minute checks were on Resident #1's care plan. Review of the facility's fifteen (15) minute check sheets for Resident #1 revealed some of the check sheets were undated and the documentation of the fifteen (15) minute checks was inconsistent, with no documented evidence of the checks for several days from 04/28/14 through 05/10/14. Further review of Resident #1's record revealed a Nurse's Note dated 05/10/14 at 2:46 PM, which was noted to be a "late entry" for 1:20 PM that same afternoon. Review of the Note revealed a staff member had observed Resident #1 "touching" other resident "inappropriately". Further review of the Note revealed a staff member was assigned for one on one (1:1) monitoring of Resident #1. Review of the facility's initial Incident Report	F 282			

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F 282	<p>Continued From page 60</p> <p>dated 05/10/14, revealed Resident #1 and Resident #2 were sitting in the hallway in their wheelchairs at 1:30 PM, when a staff member observed Resident #1 with his/her hand between Resident #2's legs while the residents were sitting in the hallway in their wheelchairs.</p> <p>Continued interview, on 05/27/14 at 10:AM, with RN #2, Charge Nurse on the unit on which Resident #1 resided, revealed she thought the fifteen (15) minutes checks were started a day or two before the 05/10/14 incident involving Resident #2; however could not recall why the resident was placed on the checks.</p> <p>Interview with the Director of Nursing (DON) on 5/29/14 at 7:25 PM, revealed her responsibilities included ensuring staff was aware of interventions to protect residents from abuse. She indicated the facility needed to have a more effective system for informing staff of resident to resident abuse. The DON stated her expectations were for staff to follow residents' care plan interventions, and protect residents from potential abuse. However, the facility failed to ensure per the facility's policy, immediate action/interventions were implemented to prevent reoccurrence of the altercation.</p> <p>The facility provided an acceptable credible AOC on 06/05/14 that alleged removal of the IJ effective 06/04/14. Review of the AOC revealed the facility implemented the following:</p> <p>1. The Administrator, DON, ADON and SDN were educated on 05/30/14 by the Regional Director of Operations for Preferred Care Partners, Management Group on Accidents and Supervision on residents must be free from</p>	F 282		

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F 282	<p>Continued From page 61</p> <p>abuse and neglect in order to ensure residents' were protected.</p> <p>2. The Quality Assurance (QA) Committee reviewed all educational materials and developed a data collection tool on 05/30/14 to validate assessments and Care Plans were being utilized per policy protocol. The tool includes a monitor for aggressive resident behaviors. If aggressive behavior occurs, interventions implemented will be reviewed for effectiveness and a determination if additional interventions are needed will be made. The tool was implemented on 05/30/14 and is ongoing.</p> <p>3. Resident #3 had a weekly skin assessment completed on 05/03/14, and Resident #2 had a weekly skin assessments completed on 05/16/14. All residents were assessed for the potential to be an abuser, assessments were completed by 06/03/14. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Staff Development Nurse (SDN), and/or the Registered Nurse (RN) Supervisor completed the assessments. Information obtained was used to develop and implement appropriate interventions, and the Care Plans were updated initially by the DON, ADON or the SDN, and will be updated thereafter by RN Unit Managers and Charge Nurses.</p> <p>4. For any resident to resident allegations, the aggressor is to be removed from the situation and placed on continuous observation until otherwise notified by the DON and/or the Administrator. CNAs will be notified of the continuous observation order via the CNA Care Plan and "Accunurse" (the CNA computer documentation system). Nurses and CNAs were educated on</p>	F 282			

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F 282	Continued From page 62 the process by the DON, ADON or SDN, with the education completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. The facility does not use agency staff. 5. The Administrator and the DON educated the ADON, SDN, RN Unit Managers, Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist tool, with the education completed by 06/03/14. The Administrator and the DON will monitor use of the checklist for every abuse investigation. The facility's general orientation for new hires was revised to include the education. 6. Licensed nursing staff were educated on performing assessments, interventions and updating the Care Plan, implementation and use of the Care Plan, the components of accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. The education was provided by the DON, ADON and SDN, and completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. 7. All facility staff were educated on identifying and reporting abuse, with a focus on resident to resident sexual aggression, and on resident rights. The education was provided by the DON, ADON and SDN, and was completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. 8. The Administrator or the DON will notify the Office of Inspector General, Adult Protective Services, the Ombudsman, and local law enforcement of all sexually aggressive behaviors	F 282			

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F 282	Continued From page 63 as required by law and within specified time limits. 9. Educational records will be maintained and will include signatures of attendance, signatures of the education received, and copies of tests designed to determine the effectiveness of the education initiated on 05/30/14 and completed by 06/03/14. 10. The Administrator is charged to administer the facility in a safe and efficient manner to assure the safety of the residents at all times. The Administrator, in conjunction with the DON, ADON and SDN, will assure education is provided and resident care and treatment is delivered in accordance with the Care Plan. Continued evaluation, assessment and Care Plan updates will be used to ensure all residents are safe from harm. 11. Monitoring and utilizing the (QA) Committee data collection tool developed on 05/30/14, is done by the DON, ADON, SDN, RN Unit Managers and RN Supervisors. QA meetings to review the collected data will be held five (5) days per week, and as needed, for thirty (30) days, then weekly for thirty (30) days, then monthly or as needed thereafter. Any identified concerns will be corrected immediately. The State Agency validated the implementation of the facility's AOC as follows: 1. Review of the education sign-in sheets revealed the Administrator, DON, ADON and SDN were educated by the Regional Director of Operations on 05/30/14, prior to the administrative team conducting education of all facility staff. Continued review revealed topics	F 282			

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F 282	Continued From page 64 covered included supervision of incidents/accidents; abuse reporting; conducting investigations, and reviewing residents who are at risk or cognitively impaired. Interview with the Administrator, on 06/06/14 at 1:30 PM, revealed the Regional Director of Operations performed the education for the DON, ADON, SDN and himself on 05/30/14. The Administrator stated the education was to ensure all residents were free from abuse and the facility was administered in a manner to assist residents to achieve their highest physical, mental and psychosocial well-being. 2. Review of the data collection tool developed by the QA Committee revealed it included, but was not limited to, validation of assessments completed, use of Care Plans, and a monitor of resident behaviors. In addition, in the case of aggressive behaviors, the tool allowed for a review of current interventions for effectiveness and a determination of the need for additional interventions. Interview with the DON and the Administrator, on 06/05/14 at 4:45 PM, revealed the tool was developed and implemented on 05/30/14, and was being used as outlined in the AOC ongoing. 3. Review of Resident #3's record revealed a weekly skin assessment was completed on 05/03/14, with no documented evidence of physical injury. Review of Resident #2's record revealed a weekly skin assessment was completed on 05/16/14, with no documented evidence of physical injury. Review of the facility's implementation	F 282			

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F 282	<p>Continued From page 65</p> <p>documentation binder for the AOC revealed all residents were assessed, care plans were reviewed and updated for residents with identified behaviors, as alleged by the DON, ADON, SDN and RN Supervisor.</p> <p>Interview with the DON, on 06/05/14 at 2:20 PM, revealed she reviewed Resident #3's weekly skin assessment dated 05/03/14, and Resident #2's weekly skin assessment dated 05/16/14 and confirmed the residents had no physical injuries documented on those dates. The DON stated all residents in the facility were assessed, and those with behaviors were monitored for the potential to be an abuser, care planned for the behaviors, and any behaviors were documented every shift. In addition, all new admissions were assessed for any history of behaviors and care planned accordingly.</p> <p>4. Review of the facility's implementation documentation binder for the AOC revealed staff signatures of nurses and CNAs who received the education on residents on continuous supervision, updating and following residents' care plans, use of the Abuse Allegation Checklist and completed post-tests successfully. Continued review revealed all education was provided on or prior to 06/03/14 as alleged.</p> <p>Review of the Abuse Allegation Checklist form utilized by the facility revealed it included removing the aggressor resident and placing the resident on continuous observation. Review of the QA Data Collection tool revealed monitoring included whether staff used the Abuse Allegation Checklist after each incident.</p> <p>Review of the ongoing investigation file for the</p>	F 282			

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F 282	Continued From page 66 only resident to resident incident after implementation of the AOC revealed the Abuse Allegation Checklist was used, the aggressor resident was removed from the situation, and 1:1 supervision was initiated and thoroughly documented on. Review of the CNA Worksheet/Care Plan for the resident aggressor revealed it was updated to reflect the increased supervision. Interviews 06/05/14 with CNA #6 at 2:45 PM; CNA #7 at 3:40 PM; and CNA #8 at 3:45 PM, revealed the CNAs education on residents on continuous supervision would be in the "Accunurse" computer system and on the CNA Worksheet/Care Plan. The CNAs reported receiving education related to providing the one on one (1:1) supervision and ensuring they documented the continuous supervision. Interviews 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and, LPN #9 at 3:35 PM, revealed the nurses were educated on use of the Abuse Allegation Checklist, and updating and ensuring the CNAs and they followed residents' care plans. 5. Review of the facility's implementation documentation binder for the AOC revealed education sign-in sheets and post-tests for the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors who attended the education provided by the Administrator and DON. Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they educated the ADON, SDN, RN Unit Managers, RN Shift	F 282			

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F 282	<p>Continued From page 67</p> <p>Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist, on or before 06/03/14. The Administrator and DON stated they were monitoring for use of the Checklist with every abuse investigation. They reported the education had been added to the facility's general orientation for new hires.</p> <p>Interview with RN Supervisor #1, on 06/05/14 at 3:15 PM, revealed she had received the education provided, took a post-test and was knowledgeable about when and how to use the Abuse Investigation Checklist.</p> <p>6. Review of the facility's implementation documentation binder for the AOC revealed licensed nursing staff received mandatory education related to performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. Review of the Sign-in sheets reflected the nurses' attendance, and their completion of the post-tests which cross-matched with the signatures. Continued review revealed all education was received on or prior to 06/03/14 by the DON, ADON and SDN.</p> <p>Interviews on 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3.30 PM; and LPN #9 at 3:35 PM, revealed the nurses confirmed receiving the education on performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents and had taken the post-test afterwards.</p>	F 282		

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F 282	Continued From page 68 Interview with the DON on 06/06/14 at 4:45 PM, revealed the education had been provided prior to 06/03/14 as per the AOC for all licensed nursing staff. The DON stated the education had been added to the facility's general orientation for new hires. 7. Review of the facility's implementation documentation binder for the AOC revealed all facility staff had received education on abuse which included identifying and reporting abuse, resident to resident sexual aggression and Resident Rights. Continued review of the binder revealed a master list of employees, education sign-in sheets and post-tests which were cross-referenced to confirm the education. Interview with the SDN on 06/05/14 at 4:30 PM, revealed she had participated in providing education for all facility staff related to abuse and Resident Rights. She stated each Department Head had a list of all staff who still needed to receive the education prior to returning to work and ensured the education was provided before the employee was allowed to work. Interview with the DON, on 06/06/14 at 4:45 PM, revealed the facility ensured all facility staff received the mandatory education on abuse and Resident Rights, as per the AOC, by maintaining a master list of all staff and checking off names as they received the education. She stated a list of all staff on vacation or other leave included their return to work date, and no staff were allowed to be on duty prior to the education being completed. Interviews on 06/05/14 with: Dietary Personnel #1	F 282			

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F 282	<p>Continued From page 69</p> <p>at 2:00 PM, Dietary Personnel #2 at 2:05 PM; Maintenance Assistant #1 at 2:15 PM; Social Services (SS) Assistant #1 at 2:18 PM; Laundry Personnel #1 at 2:20 PM; Occupational Therapist (OT) #1 at 2:23 PM; LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; CNA #6 at 2:45 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; LPN #9 at 3:35 PM; CNA #7 at 3:40 PM; and, CNA #8 at 3:45 PM revealed they all had attended the mandatory inservices related to abuse and Resident Rights. Those interviewed were able to explain their responsibilities if abuse were observed, reported or suspected. All interviewees were cross-checked to the education sign-in sheets and post-tests.</p> <p>8. Review of the facility's implementation documentation binder for the AOC revealed an ongoing investigation of a resident to resident altercation, which was not sexual in nature. Review of the investigation documentation revealed all required notifications were made timely in accordance with facility policy and federal and state regulations.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they would ensure notification of the State Survey Agency, Adult Protective Services, the Ombudsman and local law enforcement of all sexually aggressive behaviors as indicated in the AOC. However, they reported no incidents of sexually aggressive behaviors had occurred since the alleged date of compliance, 06/04/14.</p> <p>9. Review of the facility's implementation documentation binder for the AOC revealed education records included sign-in sheets for all</p>	F 282			

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F 282	Continued From page 70 education provided. Continued review revealed staff members were checked off from a master list of all employees in order for the facility to ensure every staff member received the education prior to returning to work. In addition, copies of completed post-tests were available for review and were cross-checked with the sign-in sheets. A review of educational offering agendas revealed all topics included in the AOC were provided. Further review revealed all education was completed prior to or on 06/03/14 as alleged. Interview with the Administrator and the DON on 06/05/14 at 4:45 PM, revealed all the education was mandatory with records being maintained. Interview with the SDN, on 06/05/14 at 4:30 PM, revealed she tracked employee attendance via the sign-in sheets and the master list. She stated she tried to make the inservices interesting to maintain the learners' attention, and utilized post-tests to verify effectiveness of the education. 10. Interview with the Administrator and the DON on 06/06/14 at 1:30 PM, revealed the Administrator was responsible for the overall administration of the facility. He stated his goal was to ensure every resident was safe and staff were knowledgeable regarding providing care according to the written Care Plan. He further stated he had been closely involved with the DON throughout the development and implementation of the AOC, including the monitoring of data collected as part of the QA process. The Administrator stated he and the DON ensured the education was provided. He indicated the facility would continue to evaluate, assess and update residents' Care Plans to ensure all residents were safe from harm. Both the Administrator and the DON stated every action outlined in the AOC had	F 282			

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F 282	Continued From page 71 been conducted as alleged. 11. Review of the facility's implementation documentation binder for the AOC revealed residents' behaviors were documented by staff every shift. Continued review revealed QA team members reviewed the collected data daily Monday through Friday. Interview with the DON revealed she reviewed all documented behaviors daily Monday through Friday to ensure the Care Plans were revised to include new interventions as indicated by the exhibited behavior. She stated the data is collected by her, the ADON, SDN, RN Unit Managers and RN Supervisors, with all behaviors reviewed by her.	F 282	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, incident report, and investigation it was determined the facility's Administration failed to have an effective system in place to ensure policy and procedures were implemented to ensure each resident was free from abuse and to ensure care plan interventions related to supervision were implemented to	F 490	F490 1. All residents are at risk for abuse due to physical dependency, decreased cognition, and decreased mobility. All staff was in-serviced on how to recognize the signs and symptoms of abuse by DON, Staff Development RN, or ADON by 7/3/14. New protocol has been developed to ensure that potential abusers are identified and interventions are implemented in an attempt to prevent resident to resident abuse. 2. All residents were evaluated for potential to be an abuser. This was completed by 7/3/14 by the DON, Assistant Director of Nursing, Staff Development RN, and/or RN Supervisor. Information from the evaluation determines if additional assessment and interventions would be necessary for each resident in the center. Appropriate interventions were implemented and Care Plans updated initially 7/3/14 by DON, Assistant Director of Nursing, Staff Development RN and thereafter RN Unit Managers and Charge Nurse.	

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F 490	<p>Continued From page 72</p> <p>prevent reoccurrence of potential abuse. The facility's failure affected two (2) of ten (10) sampled residents (Residents #2 and #3).</p> <p>On 04/27/14, Resident #3 reported being touched on the inner thigh under his/her clothes by Resident #1. Resident #3 reported the incident occurred on 04/26/14. The facility initiated their investigation of the incident immediately; however, their actions did not include a physical assessment of Resident #3 for possible injury. Although cognitively intact residents on the unit were interviewed by the facility, non-interviewable residents were not assessed for signs of possible abuse. In addition, the facility revised Resident #1's plan of care to implemented visual checks of the resident every fifteen (15) minutes; however, review of documentation and interviews with staff revealed the checks were not conducted consistently. As a result of the facility's failure to monitor Resident #1, other residents were not protected from potential abuse. On 05/10/14, a staff member observed Resident #1 to have his/her hand between Resident #2's legs. Resident #1 was placed on 1:1 supervision at that time, until transferred to the hospital for further evaluation. The resident was discharged from the facility prior to initiation of the survey, and was not available for observation or interview. (Refer to F-223, F-225, F-226, F-282 and F-520.)</p> <p>The facility Administration's failure to have an effective system in place to ensure policy and procedures were implemented to ensure each resident was free from abuse and to ensure care plan interventions related to supervision were implemented to prevent reoccurrence of potential abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy</p>	F 490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>3. Administrator, DON, ADON, and Staff Education RN were educated on 5/30/14 by the Regional Director of Operations for Preferred Care Partners, Management Group on Accidents and Supervision. The residents must be free of abuse and neglect and hazard in order to achieve their highest practicable physical, mental and psychosocial well being. The administrator through his or her designee which will be the DON, Assistant Director of Nursing, Staff Development RN will assure through in-service education and by example, that the residents are given care and treatment in accordance with the Care Plan. The monitoring is done by the DON, Assistant Director of Nursing, Staff Development RN, RN Unit Managers, RN Supervisor by reviewing 50% resident's documentation daily minimally 5 days a week for 30 days or additionally as necessary until 7/21/14, then one time weekly until 8/21/14 or as needed, then monthly thereafter or as needed sooner.</p>	

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F 490	Continued From page 73 (IJ) was identified on 05/28/14 and determined to exist on 04/27/14. The facility was notified of the Immediate Jeopardy on 05/28/14. The facility provided an acceptable credible Allegation of Compliance (AOC) on 06/05/14 with the facility alleging removal of the IJ on 06/04/14. The IJ was verified to be removed on 06/04/14 as alleged, prior to exit from the facility on 06/06/14, with remaining non-compliance at 42 CFR 483.75, F-490 Administration with a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance program continues to monitor to ensure residents are free from abuse. The findings include: Review of the facility's policy titled, "Abuse Resident to Resident", effective October 2012, revealed all residents had the right to be free from any mental or physical mistreatment. Immediate action was to be taken in any occurrence of a resident to resident altercation with immediate interventions taken to prevent reoccurrence. Continued review of the policy revealed measures included monitoring of residents at the nurses station, and one on one (1:1) therapy/activity and discharge to the hospital for medical evaluation if necessary. Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed an individualized comprehensive care plan which included measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs was to be developed for each resident. Further review of the policy revealed each resident's care plan was	F 490	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Any issues identified are corrected immediately and the Administrator is notified by the DON. The Administrator will oversee the monitoring process by receiving daily audits daily 5 days a week for 30 days or additionally as necessary until 8/2/14 and then as needed. Those issues and the effectiveness of the additional interventions are taken to QA on the same day. This practice became effective 6/3/14. 4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the Medical Director Quarterly. Next meeting with Medical Director will be held in July. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted		

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F 490	<p>Continued From page 74</p> <p>designed to identify the professional services that were responsible for each element of care.</p> <p>No policy related to Administration was provided.</p> <p>Review of the facility's Incident Report form dated 04/27/14, revealed the facility reported Resident #1 "touched" Resident #3 on the leg under his/her clothes on 04/26/14. Continued review revealed Resident #3 expressed fear of Resident #1 after the incident.</p> <p>Review of the facility's investigation of the incident reported on 04/27/14, revealed no documented evidence non-interviewable residents, those with a Brief Interview for Mental Status (BIMS) score of less than 8, were questioned or physically assessed for signs of possible abuse by Resident #1, the alleged perpetrator. Continued review revealed Resident #3 was not assessed for any evidence of sexual assault or other injury after the incident on 04/27/14.</p> <p>Record review revealed the facility revised Resident #1's care plan to include fifteen (15) minute checks after the 04/27/14 incident. However, there was no documented evidence the fifteen (15) minute checks were consistently completed. In addition, staff interviews revealed this intervention was not communicated to all staff and there was confusion as to who was responsible to conduct the checks.</p> <p>On 05/10/14, Resident #1 was observed to "grope" another resident (Resident #2). Record review revealed Resident #2 was not assessed for injury.</p> <p>Interview with the Director of Nursing (DON) and</p>	F 490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>membership includes the Medical Director.</p> <p>5. Date of Compliance:</p>	7/7/14	

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F 490	Continued From page 75 the Administrator on 05/29/14 at 5:35 PM, revealed after the 04/26/14 incident she instructed the staff to place Resident #1 on fifteen (15) minute checks. The DON acknowledged the checks were not done and/or had been inconsistently documented and the care plan not implemented per the facility's policy. The Administrator stated he was informed of the incident on 04/27/14 by the DON. He stated the DON kept him informed as the investigation proceeded. Continued interview with the DON and the Administrator revealed they felt they had done everything they could to ensure all residents were protected. The DON stated she believed the fifteen (15) minute checks provided adequate supervision and monitoring of Resident #1 because no staff reported the resident to be engaged in any inappropriate behaviors prior to 05/10/14, when Resident #1 was observed to have his/her hand between Resident #2's legs. However, there was no evidence the 15 minutes checks were consistently conducted, and interviews with staff revealed some were not aware Resident #1 was on 15 minutes checks. The Administrator further stated the facility went "above and beyond" by continuing the fifteen (15) minutes checks past the typical seventy-two (72) hour period when increased monitoring was indicated, despite the fact of the lack of, and inconsistent, documentation of the checks during the period between 04/28/14 and 05/10/14. Subsequent interview with the DON, on 05/29/14 at 7:25 PM, revealed head to toe skin assessments should have been completed on Residents #2 and #3 after the incidents were reported. She stated additional interventions should have been put in place to protect Resident #3 after the facility became aware, on 04/27/14,	F 490			

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F 490	<p>Continued From page 76</p> <p>of the resident's allegation regarding Resident #1, and Residents #2 and #3 should have been monitored to determine how they were coping after the incidents. The DON indicated her responsibilities included ensuring facility staff were notified of incidents involving abuse and knew how to implement policies and procedures. The DON indicated the facility needed to create a more effective system of communicating incidents of resident to resident abuse to staff.</p> <p>The facility provided an acceptable credible AOC on 06/05/14 that alleged removal of the IJ effective 06/04/14. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. The Administrator, DON, ADON and SDN were educated on 05/30/14 by the Regional Director of Operations for Preferred Care Partners, Management Group on Accidents and Supervision on residents must be free from abuse and neglect in order to ensure residents' were protected. 2. The Quality Assurance (QA) Committee reviewed all educational materials and developed a data collection tool on 05/30/14 to validate assessments and Care Plans were being utilized per policy protocol. The tool includes a monitor for aggressive resident behaviors. If aggressive behavior occurs, interventions implemented will be reviewed for effectiveness and a determination if additional interventions are needed will be made. The tool was implemented on 05/30/14 and is ongoing. 3. Resident #3 had a weekly skin assessment completed on 05/03/14, and Resident #2 had a weekly skin assessments completed on 05/16/14. 	F 490		

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F 490	Continued From page 77 All residents were assessed for the potential to be an abuser, assessments were completed by 06/03/14. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Staff Development Nurse (SDN), and/or the Registered Nurse (RN) Supervisor completed the assessments. Information obtained was used to develop and implement appropriate interventions, and the Care Plans were updated initially by the DON, ADON or the SDN, and will be updated thereafter by RN Unit Managers and Charge Nurses. 4. For any resident to resident allegations, the aggressor is to be removed from the situation and placed on continuous observation until otherwise notified by the DON and/or the Administrator. CNAs will be notified of the continuous observation order via the CNA Care Plan and "Accunurse" (the CNA computer documentation system). Nurses and CNAs were educated on the process by the DON, ADON or SDN, with the education completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. The facility does not use agency staff. 5. The Administrator and the DON educated the ADON, SDN, RN Unit Managers, Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist tool, with the education completed by 06/03/14. The Administrator and the DON will monitor use of the checklist for every abuse investigation. The facility's general orientation for new hires was revised to include the education. 6. Licensed nursing staff were educated on performing assessments, interventions and	F 490			

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F 490 Continued From page 78

updating the Care Plan, implementation and use of the Care Plan, the components of accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. The education was provided by the DON, ADON and SDN, and completed by 06/03/14. The facility's general orientation for new hires was revised to include the education.

7. All facility staff were educated on identifying and reporting abuse, with a focus on resident to resident sexual aggression, and on resident rights. The education was provided by the DON, ADON and SDN, and was completed by 06/03/14. The facility's general orientation for new hires was revised to include the education.

8. The Administrator or the DON will notify the Office of Inspector General, Adult Protective Services, the Ombudsman, and local law enforcement of all sexually aggressive behaviors as required by law and within specified time limits.

9. Educational records will be maintained and will include signatures of attendance, signatures of the education received, and copies of tests designed to determine the effectiveness of the education initiated on 05/30/14 and completed by 06/03/14.

10. The Administrator is charged to administer the facility in a safe and efficient manner to assure the safety of the residents at all times. The Administrator, in conjunction with the DON, ADON and SDN, will assure education is provided and resident care and treatment is delivered in accordance with the Care Plan. Continued evaluation, assessment and Care Plan updates will be used to ensure all residents are

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F 490	<p>Continued From page 79 safe from harm.</p> <p>11. Monitoring and utilizing the (QA) Committee data collection tool developed on 05/30/14, is done by the DON, ADON, SDN, RN Unit Managers and RN Supervisors. QA meetings to review the collected data will be held five (5) days per week, and as needed, for thirty (30) days, then weekly for thirty (30) days, then monthly or as needed thereafter. Any identified concerns will be corrected immediately.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the education sign-in sheets revealed the Administrator, DON, ADON and SDN were educated by the Regional Director of Operations on 05/30/14, prior to the administrative team conducting education of all facility staff. Continued review revealed topics covered included supervision of incidents/accidents; abuse reporting; conducting investigations, and reviewing residents who are at risk or cognitively impaired.</p> <p>Interview with the Administrator, on 06/06/14 at 1:30 PM, revealed the Regional Director of Operations performed the education for the DON, ADON, SDN and himself on 05/30/14. The Administrator stated the education was to ensure all residents were free from abuse and the facility was administered in a manner to assist residents to achieve their highest physical, mental and psychosocial well-being.</p> <p>2. Review of the data collection tool developed by the QA Committee revealed it included, but was not limited to, validation of assessments</p>	F 490			

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F 490 | Continued From page 80

completed, use of Care Plans, and a monitor of resident behaviors. In addition, in the case of aggressive behaviors, the tool allowed for a review of current interventions for effectiveness and a determination of the need for additional interventions.

Interview with the DON and the Administrator, on 06/05/14 at 4:45 PM, revealed the tool was developed and implemented on 05/30/14, and was being used as outlined in the AOC ongoing.

3. Review of Resident #3's record revealed a weekly skin assessment was completed on 05/03/14, with no documented evidence of physical injury. Review of Resident #2's record revealed a weekly skin assessment was completed on 05/16/14, with no documented evidence of physical injury.

Review of the facility's implementation documentation binder for the AOC revealed all residents were assessed, care plans were reviewed and updated for residents with identified behaviors, as alleged by the DON, ADON, SDN and RN Supervisor.

Interview with the DON, on 06/05/14 at 2:20 PM, revealed she reviewed Resident #3's weekly skin assessment dated 05/03/14, and Resident #2's weekly skin assessment dated 05/16/14 and confirmed the residents had no physical injuries documented on those dates. The DON stated all residents in the facility were assessed, and those with behaviors were monitored for the potential to be an abuser, care planned for the behaviors, and any behaviors were documented every shift. In addition, all new admissions were assessed for any history of behaviors and care planned

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F 490	Continued From page 81 accordingly. 4. Review of the facility's implementation documentation binder for the AOC revealed staff signatures of nurses and CNAs who received the education on residents on continuous supervision, updating and following residents' care plans, use of the Abuse Allegation Checklist and completed post-tests successfully. Continued review revealed all education was provided on or prior to 06/03/14 as alleged. Review of the Abuse Allegation Checklist form utilized by the facility revealed it included removing the aggressor resident and placing the resident on continuous observation. Review of the QA Data Collection tool revealed monitoring included whether staff used the Abuse Allegation Checklist after each incident. Review of the ongoing investigation file for the only resident to resident incident after implementation of the AOC revealed the Abuse Allegation Checklist was used, the aggressor resident was removed from the situation, and 1:1 supervision was initiated and thoroughly documented on. Review of the CNA Worksheet/Care Plan for the resident aggressor revealed it was updated to reflect the increased supervision. Interviews 06/05/14 with CNA #6 at 2:45 PM; CNA #7 at 3:40 PM; and CNA #8 at 3:45 PM, revealed the CNAs education on residents on continuous supervision would be in the "Accunurse" computer system and on the CNA Worksheet/Care Plan. The CNAs reported receiving education related to providing the one on one (1:1) supervision and ensuring they	F 490			

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F 490	<p>Continued From page 82 documented the continuous supervision.</p> <p>Interviews 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and, LPN #9 at 3:35 PM, revealed the nurses were educated on use of the Abuse Allegation Checklist, and updating and ensuring the CNAs and they followed residents' care plans.</p> <p>5. Review of the facility's implementation documentation binder for the AOC revealed education sign-in sheets and post-tests for the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors who attended the education provided by the Administrator and DON.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they educated the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist, on or before 06/03/14. The Administrator and DON stated they were monitoring for use of the Checklist with every abuse investigation. They reported the education had been added to the facility's general orientation for new hires.</p> <p>Interview with RN Supervisor #1, on 06/05/14 at 3:15 PM, revealed she had received the education provided, took a post-test and was knowledgeable about when and how to use the Abuse Investigation Checklist.</p> <p>6. Review of the facility's implementation documentation binder for the AOC revealed licensed nursing staff received mandatory education related to performing assessments,</p>	F 490		

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F 490	<p>Continued From page 83</p> <p>interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. Review of the Sign-in sheets reflected the nurses' attendance, and their completion of the post-tests which cross-matched with the signatures. Continued review revealed all education was received on or prior to 06/03/14 by the DON, ADON and SDN.</p> <p>Interviews on 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and LPN #9 at 3:35 PM, revealed the nurses confirmed receiving the education on performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents and had taken the post-test afterwards.</p> <p>Interview with the DON on 06/06/14 at 4:45 PM, revealed the education had been provided prior to 06/03/14 as per the AOC for all licensed nursing staff. The DON stated the education had been added to the facility's general orientation for new hires.</p> <p>7. Review of the facility's implementation documentation binder for the AOC revealed all facility staff had received education on abuse which included identifying and reporting abuse, resident to resident sexual aggression and Resident Rights. Continued review of the binder revealed a master list of employees, education sign-in sheets and post-tests which were cross-referenced to confirm the education.</p>	F 490		

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F 490	<p>Continued From page 84</p> <p>Interview with the SDN on 06/05/14 at 4:30 PM, revealed she had participated in providing education for all facility staff related to abuse and Resident Rights. She stated each Department Head had a list of all staff who still needed to receive the education prior to returning to work and ensured the education was provided before the employee was allowed to work.</p> <p>Interview with the DON, on 06/06/14 at 4:45 PM, revealed the facility ensured all facility staff received the mandatory education on abuse and Resident Rights, as per the AOC, by maintaining a master list of all staff and checking off names as they received the education. She stated a list of all staff on vacation or other leave included their return to work date, and no staff were allowed to be on duty prior to the education being completed.</p> <p>Interviews on 06/05/14 with: Dietary Personnel #1 at 2:00 PM; Dietary Personnel #2 at 2:05 PM; Maintenance Assistant #1 at 2:15 PM; Social Services (SS) Assistant #1 at 2:18 PM; Laundry Personnel #1 at 2:20 PM; Occupational Therapist (OT) #1 at 2:23 PM; LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; CNA #6 at 2:45 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; LPN #9 at 3:35 PM; CNA #7 at 3:40 PM; and, CNA #8 at 3:45 PM revealed they all had attended the mandatory inservices related to abuse and Resident Rights. Those interviewed were able to explain their responsibilities if abuse were observed, reported or suspected. All interviewees were cross-checked to the education sign-in sheets and post-tests.</p> <p>8. Review of the facility's implementation</p>	F 490			

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F 490	<p>Continued From page 85</p> <p>documentation binder for the AOC revealed an ongoing investigation of a resident to resident altercation, which was not sexual in nature. Review of the investigation documentation revealed all required notifications were made timely in accordance with facility policy and federal and state regulations.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they would ensure notification of the State Survey Agency, Adult Protective Services, the Ombudsman and local law enforcement of all sexually aggressive behaviors as indicated in the AOC. However, they reported no incidents of sexually aggressive behaviors had occurred since the alleged date of compliance, 06/04/14.</p> <p>9. Review of the facility's implementation documentation binder for the AOC revealed education records included sign-in sheets for all education provided. Continued review revealed staff members were checked off from a master list of all employees in order for the facility to ensure every staff member received the education prior to returning to work. In addition, copies of completed post-tests were available for review and were cross-checked with the sign-in sheets. A review of educational offering agendas revealed all topics included in the AOC were provided. Further review revealed all education was completed prior to or on 06/03/14 as alleged.</p> <p>Interview with the Administrator and the DON on 06/05/14 at 4:45 PM, revealed all the education was mandatory with records being maintained. Interview with the SDN, on 06/05/14 at 4:30 PM, revealed she tracked employee attendance via the sign-in sheets and the master list. She stated</p>	F 490			

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F 490	<p>Continued From page 86</p> <p>she tried to make the inservices interesting to maintain the learners' attention, and utilized post-tests to verify effectiveness of the education.</p> <p>10. Interview with the Administrator and the DON on 06/06/14 at 1:30 PM, revealed the Administrator was responsible for the overall administration of the facility. He stated his goal was to ensure every resident was safe and staff were knowledgeable regarding providing care according to the written Care Plan. He further stated he had been closely involved with the DON throughout the development and implementation of the AOC, including the monitoring of data collected as part of the QA process. The Administrator stated he and the DON ensured the education was provided. He indicated the facility would continue to evaluate, assess and update residents' Care Plans to ensure all residents were safe from harm. Both the Administrator and the DON stated every action outlined in the AOC had been conducted as alleged.</p> <p>11. Review of the facility's implementation documentation binder for the AOC revealed residents' behaviors were documented by staff every shift. Continued review revealed QA team members reviewed the collected data daily Monday through Friday.</p> <p>Interview with the DON revealed she reviewed all documented behaviors daily Monday through Friday to ensure the Care Plans were revised to include new interventions as indicated by the exhibited behavior. She stated the data is collected by her, the ADON, SDN, RN Unit Managers and RN Supervisors, with all behaviors reviewed by her.</p>	F 490		

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F 520 F 520 SS=J	Continued From page 87 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to identify a Quality Assurance (QA) concern, and develop and implement an appropriate plan of action, when an allegation of resident to resident sexual abuse was made. The failure affected two (2) of	F 520 F 520	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F520 1. IDT meeting revised on 6/2/14 to include signatures of team members present during discussion. Quality Assurance Committee members reviewed minimally 5 days a week for 30 days or additionally as necessary until 7/21/14; then one time weekly until 8/21/14 or as needed; then monthly thereafter or as needed sooner. 2. IDT meeting revised on 6/2/14 to include signatures of team members present during discussion Quality Assurance Committee members reviewed minimally 5 days a week for 30 days or additionally as necessary until 7/21/14; then one time weekly until 8/21/14 or as needed; then monthly thereafter or as needed sooner. 3. On 7/3/14 the IDT meeting was revised to include documentation of what was discussed and any identified follow up needed. Education on the updated process was completed by the Director of Nursing on 7/3/14 to all IDT members. Administrator and DON		

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F 520	<p>Continued From page 88</p> <p>ten (10) sampled residents (Residents #2 and #3).</p> <p>On 04/27/14, Resident #3 reported to staff he/she was touched on the inner thigh under his/her clothes by Resident #1. Resident #3 further reported the incident occurred on 04/26/14. The facility had a weekly Interdisciplinary Team (IDT) meeting on 04/28/14, during which the incident was reviewed. Staff was directed to perform every fifteen (15) minute checks on Resident #1; however, no monitoring system was put in place to ensure the checks were completed as directed. In addition, review of the fifteen (15) minute check sheets revealed no documented evidence the checks were performed consistently every fifteen (15) minutes, or documented to include the date the checks were performed. As a result of the facility's failure to monitor Resident #1, other residents were not protected from potential abuse. On 05/10/14, a staff member observed Resident #1 to have his/her hand between Resident #2's legs. Resident #1 was placed on 1:1 supervision at that time, until transferred to the hospital for further evaluation. The resident was discharged from the facility prior to initiation of the survey, and was not available for observation or interview. (Refer to F-223, F-225, F-226, F-282 and F-490)</p> <p>The failure of the facility's QA program to identify and develop an appropriate plan of action after an allegation of abuse, to prevent a reoccurrence of potential abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) was identified on 05/28/14 and determined to exist on 04/27/14. The facility was notified of the Immediate Jeopardy on 05/28/14.</p>	F 520	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>educated Assistant Director of Nursing, Staff Development RN, RN Unit Manager, Shift Supervisors, and Weekend Supervisor as to the purpose of the Abuse Investigation Checklist and use of this tool with completion by 7/3/14. Administrator and DON will monitor use of checklist with every abuse investigation as needed. Administrator or Director of Nursing will audit Quality Assurance Committee meetings and IDT meetings for completed follow-up minimally 5 days a week for 30 days or additionally as necessary until 8/2/14; then one time weekly until 9/2/14 or as needed; then monthly thereafter or as needed sooner.</p> <p>4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the Medical Director Quarterly. Next meeting with Medical Director will be held in July. The Quality</p>		

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F 520	Continued From page 89 The facility provided an acceptable credible Allegation of Compliance (AOC) on 06/05/14, with the facility alleging removal of the IJ on 06/04/14. The IJ was verified to be removed on 06/04/14 as alleged, prior to exit from the facility on 06/06/14, with remaining non-compliance at 42 CFR 483.75 Administration, F-520 with a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance program monitors to ensure residents are free from abuse. The findings include: Review of the facility's policy, titled "QA Committee Meeting Process" (dated 08/2008), revealed the facility's QA Committee met weekly as an IDT to discuss resident information and make recommendations. Continued review of the policy revealed five (5) areas, including incidents and accidents, were to be reviewed at each meeting. Review of the facility's Incident Report form, dated 04/27/14, revealed the facility reported Resident #1 "touched" Resident #3 on the leg under his/her clothes on 04/26/14. Continued review revealed Resident #3 expressed fear of Resident #1 after the incident. Review of Resident #1's Care Plan revealed it was revised to include every fifteen (15) minute checks after the 04/27/14 incident. However, the facility could not provide documented evidence the fifteen (15) minute checks were consistently performed. Review of the check sheets that were present in the medical record revealed the checks that were documented did not always	F 520	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director. 5. Date of Compliance:	7/7/14	

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F 520	<p>Continued From page 90</p> <p>include the date the action took place. In addition, staff interviews revealed all were not aware the intervention for fifteen (15) minute checks had been implemented, and there was confusion as to who was responsible for conducting the checks.</p> <p>On 05/10/14, Resident #1 was observed by a staff member to "grope" another resident (Resident #2). At that time, Resident #1 was placed on 1:1 observation until transferred out to the hospital for further evaluation.</p> <p>A post-survey telephone interview with the Administrator and the Director of Nursing (DON), conducted on 06/30/14 at 10:35 AM, revealed the facility conducted an IDT meeting weekly, as part of the overall QA program. Attendees included Clinical Managers and the Administrator. Continued interview revealed the incident reported by Resident #3 on 04/27/14 was discussed by the IDT at the weekly meeting on 04/28/14. The DON stated she could not be sure whether she directed staff to perform every fifteen (15) minute checks of Resident #1 on 04/27/14 when the incident was reported, or on 04/28/14 as a result of the IDT meeting. She further stated, in either case the frequent checks were determined by the IDT to be the appropriate plan of action in response to the incident involving Residents #3 and #1.</p> <p>However, continued interview with the Administrator and the DON, on 06/30/14 at 10:35 AM, revealed no formal QA action plan or monitoring was initiated after the 04/27/14 allegation of abuse involving Resident #1. The facility did not perform any monitoring to ensure the fifteen (15) minute checks were completed.</p>	F 520		

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F 520 Continued From page 91

The DON and the Administrator were unaware the checks were not performed and/or documented consistently. In addition, the Administrator and the DON did not know some nursing staff were unaware of a directive for the fifteen (15) minute checks.

The facility provided an acceptable credible AOC on 06/05/14 that alleged removal of the IJ effective 06/04/14. Review of the AOC revealed the facility implemented the following:

1. The Administrator, DON, ADON and SDN were educated on 05/30/14 by the Regional Director of Operations for Preferred Care Partners, Management Group on Accidents and Supervision on residents must be free from abuse and neglect in order to ensure residents were protected.
2. The Quality Assurance (QA) Committee reviewed all educational materials and developed a data collection tool on 05/30/14 to validate assessments and Care Plans were being utilized per policy protocol. The tool includes a monitor for aggressive resident behaviors. If aggressive behavior occurs, interventions implemented will be reviewed for effectiveness and a determination if additional interventions are needed will be made. The tool was implemented on 05/30/14 and is ongoing.
3. Resident #3 had a weekly skin assessment completed on 05/03/14, and Resident #2 had a weekly skin assessments completed on 05/16/14. All residents were assessed for the potential to be an abuser, assessments were completed by 06/03/14. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Staff

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F 520	<p>Continued From page 92</p> <p>Development Nurse (SDN), and/or the Registered Nurse (RN) Supervisor completed the assessments. Information obtained was used to develop and implement appropriate interventions, and the Care Plans were updated initially by the DON, ADON or the SDN, and will be updated thereafter by RN Unit Managers and Charge Nurses.</p> <p>4. For any resident to resident allegations, the aggressor is to be removed from the situation and placed on continuous observation until otherwise notified by the DON and/or the Administrator. CNAs will be notified of the continuous observation order via the CNA Care Plan and "Accunurse" (the CNA computer documentation system). Nurses and CNAs were educated on the process by the DON, ADON or SDN, with the education completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. The facility does not use agency staff.</p> <p>5. The Administrator and the DON educated the ADON, SDN, RN Unit Managers, Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist tool, with the education completed by 06/03/14. The Administrator and the DON will monitor use of the checklist for every abuse investigation. The facility's general orientation for new hires was revised to include the education.</p> <p>6. Licensed nursing staff were educated on performing assessments, interventions and updating the Care Plan, implementation and use of the Care Plan, the components of accurate and thorough shift reporting, and identification, documentation and investigation of incidents and</p>	F 520		

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F 520	<p>Continued From page 93</p> <p>accidents. The education was provided by the DON, ADON and SDN, and completed by 06/03/14. The facility's general orientation for new hires was revised to include the education.</p> <p>7. All facility staff were educated on identifying and reporting abuse, with a focus on resident to resident sexual aggression, and on resident rights. The education was provided by the DON, ADON and SDN, and was completed by 06/03/14. The facility's general orientation for new hires was revised to include the education.</p> <p>8. The Administrator or the DON will notify the Office of Inspector General, Adult Protective Services, the Ombudsman, and local law enforcement of all sexually aggressive behaviors as required by law and within specified time limits.</p> <p>9. Educational records will be maintained and will include signatures of attendance, signatures of the education received, and copies of tests designed to determine the effectiveness of the education initiated on 05/30/14 and completed by 06/03/14.</p> <p>10. The Administrator is charged to administer the facility in a safe and efficient manner to assure the safety of the residents at all times. The Administrator, in conjunction with the DON, ADON and SDN, will assure education is provided and resident care and treatment is delivered in accordance with the Care Plan. Continued evaluation, assessment and Care Plan updates will be used to ensure all residents are safe from harm.</p> <p>11. Monitoring and utilizing the (QA) Committee data collection tool developed on 05/30/14, is</p>	F 520		

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F 520	<p>Continued From page 94 done by the DON, ADON, SDN, RN Unit Managers and RN Supervisors. QA meetings to review the collected data will be held five (5) days per week, and as needed, for thirty (30) days, then weekly for thirty (30) days, then monthly or as needed thereafter. Any identified concerns will be corrected immediately.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the education sign-in sheets revealed the Administrator, DON, ADON and SDN were educated by the Regional Director of Operations on 05/30/14, prior to the administrative team conducting education of all facility staff. Continued review revealed topics covered included supervision of incidents/accidents; abuse reporting; conducting investigations, and reviewing residents who are at risk or cognitively impaired.</p> <p>Interview with the Administrator, on 06/06/14 at 1:30 PM, revealed the Regional Director of Operations performed the education for the DON, ADON, SDN and himself on 05/30/14. The Administrator stated the education was to ensure all residents were free from abuse and the facility was administered in a manner to assist residents to achieve their highest physical, mental and psychosocial well-being.</p> <p>2. Review of the data collection tool developed by the QA Committee revealed it included, but was not limited to, validation of assessments completed, use of Care Plans, and a monitor of resident behaviors. In addition, in the case of aggressive behaviors, the tool allowed for a review of current interventions for effectiveness</p>
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NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018		
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F 520	<p>Continued From page 95 and a determination of the need for additional interventions.</p> <p>Interview with the DON and the Administrator, on 06/05/14 at 4:45 PM, revealed the tool was developed and implemented on 05/30/14, and was being used as outlined in the AOC ongoing.</p> <p>3. Review of Resident #3's record revealed a weekly skin assessment was completed on 05/03/14, with no documented evidence of physical injury. Review of Resident #2's record revealed a weekly skin assessment was completed on 05/16/14, with no documented evidence of physical injury.</p> <p>Review of the facility's implementation documentation binder for the AOC revealed all residents were assessed, care plans were reviewed and updated for residents with identified behaviors, as alleged by the DON, ADON, SDN and RN Supervisor.</p> <p>Interview with the DON, on 06/05/14 at 2:20 PM, revealed she reviewed Resident #3's weekly skin assessment dated 05/03/14, and Resident #2's weekly skin assessment dated 05/16/14 and confirmed the residents had no physical injuries documented on those dates. The DON stated all residents in the facility were assessed, and those with behaviors were monitored for the potential to be an abuser, care planned for the behaviors, and any behaviors were documented every shift. In addition, all new admissions were assessed for any history of behaviors and care planned accordingly.</p> <p>4. Review of the facility's implementation documentation binder for the AOC revealed staff</p>	F 520			

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F 520	<p>Continued From page 96</p> <p>signatures of nurses and CNAs who received the education on residents on continuous supervision, updating and following residents' care plans, use of the Abuse Allegation Checklist and completed post-tests successfully. Continued review revealed all education was provided on or prior to 06/03/14 as alleged.</p> <p>Review of the Abuse Allegation Checklist form utilized by the facility revealed it included removing the aggressor resident and placing the resident on continuous observation. Review of the QA Data Collection tool revealed monitoring included whether staff used the Abuse Allegation Checklist after each incident.</p> <p>Review of the ongoing investigation file for the only resident to resident incident after implementation of the AOC revealed the Abuse Allegation Checklist was used, the aggressor resident was removed from the situation, and 1:1 supervision was initiated and thoroughly documented on. Review of the CNA Worksheet/Care Plan for the resident aggressor revealed it was updated to reflect the increased supervision.</p> <p>Interviews 06/05/14 with CNA #6 at 2:45 PM; CNA #7 at 3:40 PM; and CNA #8 at 3:45 PM, revealed the CNAs education on residents on continuous supervision would be in the "Accunurse" computer system and on the CNA Worksheet/Care Plan. The CNAs reported receiving education related to providing the one on one (1:1) supervision and ensuring they documented the continuous supervision.</p> <p>Interviews 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; RN Supervisor #1 at 3:15 PM;</p>	F 520		

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F 520	<p>Continued From page 97</p> <p>LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and, LPN #9 at 3:35 PM, revealed the nurses were educated on use of the Abuse Allegation Checklist, and updating and ensuring the CNAs and they followed residents' care plans.</p> <p>5. Review of the facility's implementation documentation binder for the AOC revealed education sign-in sheets and post-tests for the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors who attended the education provided by the Administrator and DON.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they educated the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist, on or before 06/03/14. The Administrator and DON stated they were monitoring for use of the Checklist with every abuse investigation. They reported the education had been added to the facility's general orientation for new hires.</p> <p>Interview with RN Supervisor #1, on 06/05/14 at 3:15 PM, revealed she had received the education provided, took a post-test and was knowledgeable about when and how to use the Abuse Investigation Checklist.</p> <p>6. Review of the facility's implementation documentation binder for the AOC revealed licensed nursing staff received mandatory education related to performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and</p>	F 520			

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F 520	<p>Continued From page 97</p> <p>LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and, LPN #9 at 3:35 PM, revealed the nurses were educated on use of the Abuse Allegation Checklist, and updating and ensuring the CNAs and they followed residents' care plans.</p> <p>5. Review of the facility's implementation documentation binder for the AOC revealed education sign-in sheets and post-tests for the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors who attended the education provided by the Administrator and DON.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they educated the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist, on or before 06/03/14. The Administrator and DON stated they were monitoring for use of the Checklist with every abuse investigation. They reported the education had been added to the facility's general orientation for new hires.</p> <p>Interview with RN Supervisor #1, on 06/05/14 at 3:15 PM, revealed she had received the education provided, took a post-test and was knowledgeable about when and how to use the Abuse Investigation Checklist.</p> <p>6. Review of the facility's implementation documentation binder for the AOC revealed licensed nursing staff received mandatory education related to performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and</p>	F 520	

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F 520	<p>Continued From page 98</p> <p>accidents. Review of the Sign-in sheets reflected the nurses' attendance, and their completion of the post-tests which cross-matched with the signatures. Continued review revealed all education was received on or prior to 06/03/14 by the DON, ADON and SDN.</p> <p>Interviews on 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM, and LPN #9 at 3:35 PM, revealed the nurses confirmed receiving the education on performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents and had taken the post-test afterwards.</p> <p>Interview with the DON on 06/06/14 at 4:45 PM, revealed the education had been provided prior to 06/03/14 as per the AOC for all licensed nursing staff. The DON stated the education had been added to the facility's general orientation for new hires.</p> <p>7. Review of the facility's implementation documentation binder for the AOC revealed all facility staff had received education on abuse which included identifying and reporting abuse, resident to resident sexual aggression and Resident Rights. Continued review of the binder revealed a master list of employees, education sign-in sheets and post-tests which were cross-referenced to confirm the education.</p> <p>Interview with the SDN on 06/05/14 at 4:30 PM, revealed she had participated in providing education for all facility staff related to abuse and Resident Rights. She stated each Department</p>	F 520		

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F 520	Continued From page 99 Head had a list of all staff who still needed to receive the education prior to returning to work and ensured the education was provided before the employee was allowed to work. Interview with the DON, on 06/06/14 at 4:45 PM, revealed the facility ensured all facility staff received the mandatory education on abuse and Resident Rights, as per the AOC, by maintaining a master list of all staff and checking off names as they received the education. She stated a list of all staff on vacation or other leave included their return to work date, and no staff were allowed to be on duty prior to the education being completed. Interviews on 06/05/14 with: Dietary Personnel #1 at 2:00 PM; Dietary Personnel #2 at 2:05 PM; Maintenance Assistant #1 at 2:15 PM; Social Services (SS) Assistant #1 at 2:18 PM; Laundry Personnel #1 at 2:20 PM; Occupational Therapist (OT) #1 at 2:23 PM; LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; CNA #6 at 2:45 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; LPN #9 at 3:35 PM; CNA #7 at 3:40 PM; and, CNA #8 at 3:45 PM revealed they all had attended the mandatory inservices related to abuse and Resident Rights. Those interviewed were able to explain their responsibilities if abuse were observed, reported or suspected. All interviewees were cross-checked to the education sign-in sheets and post-tests. 8. Review of the facility's implementation documentation binder for the AOC revealed an ongoing investigation of a resident to resident altercation, which was not sexual in nature. Review of the investigation documentation	F 520			

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F 520	<p>Continued From page 100</p> <p>revealed all required notifications were made timely in accordance with facility policy and federal and state regulations.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they would ensure notification of the State Survey Agency, Adult Protective Services, the Ombudsman and local law enforcement of all sexually aggressive behaviors as indicated in the AOC. However, they reported no incidents of sexually aggressive behaviors had occurred since the alleged date of compliance, 06/04/14.</p> <p>9. Review of the facility's implementation documentation binder for the AOC revealed education records included sign-in sheets for all education provided. Continued review revealed staff members were checked off from a master list of all employees in order for the facility to ensure every staff member received the education prior to returning to work. In addition, copies of completed post-tests were available for review and were cross-checked with the sign-in sheets. A review of educational offering agendas revealed all topics included in the AOC were provided. Further review revealed all education was completed prior to or on 06/03/14 as alleged.</p> <p>Interview with the Administrator and the DON on 06/05/14 at 4:45 PM, revealed all the education was mandatory with records being maintained. Interview with the SDN, on 06/05/14 at 4:30 PM, revealed she tracked employee attendance via the sign-in sheets and the master list. She stated she tried to make the inservices interesting to maintain the learners' attention, and utilized post-tests to verify effectiveness of the education.</p>	F 520			

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10. Interview with the Administrator and the DON on 06/06/14 at 1:30 PM, revealed the Administrator was responsible for the overall administration of the facility. He stated his goal was to ensure every resident was safe and staff were knowledgeable regarding providing care according to the written Care Plan. He further stated he had been closely involved with the DON throughout the development and implementation of the AOC, including the monitoring of data collected as part of the QA process. The Administrator stated he and the DON ensured the education was provided. He indicated the facility would continue to evaluate, assess and update residents' Care Plans to ensure all residents were safe from harm. Both the Administrator and the DON stated every action outlined in the AOC had been conducted as alleged.

11. Review of the facility's implementation documentation binder for the AOC revealed residents' behaviors were documented by staff every shift. Continued review revealed QA team members reviewed the collected data daily Monday through Friday.

Interview with the DON revealed she reviewed all documented behaviors daily Monday through Friday to ensure the Care Plans were revised to include new interventions as indicated by the exhibited behavior. She stated the data is collected by her, the ADON, SDN, RN Unit Managers and RN Supervisors, with all behaviors reviewed by her.

F 520