STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 309	Continued From page 219 Interview with the DON, on 07/31/14 at 8:05 PM, revealed she expected the facility's protocol to be followed for Residents #16 and #36. 6. Review of the facility's policy, "Medication Orders" (undated), revealed for medications not available in the facility's emergency medication box, a STAT order should be placed with the Pharmacy. Record review revealed the facility admitted Resident #35 on 07/02/14, with diagnoses which included Chronic Obstructive Pulmonary Disease, Hypertension, Gastroesophageal Reflux Disease, Restless Leg Syndrome, Insomnia, Anxiety, Depression and Chronic Pain. Continued review revealed the resident was admitted at 2:15 PM. Review of the admission orders for Resident #35 revealed an order for Oxycodone (narcotic pain medication) 15 mg, one (1) tablet twice daily, as needed for pain. Review of the Nurses Notes, dated 07/02/14 at 8:00 PM, revealed RN #6 documented Resident #35 was upset because his/her pain medicine was not available. Continued review revealed the nurse notified the Pharmacy and was told the medication would be delivered on the night shift run at approximately midnight or 1:00 AM. The nurse documented she explained to the resident the pain medication would be given when it was received from the Pharmacy. Interview with RN #6, on 07/31/14 at 10:05 AM, revealed Resident #35 began asking for pain medication at approximately 8:00 PM on the day of admission. Continued interview revealed RN	F 309		

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F 309	Continued From page 220 #6 contacted the Pharmacy at 8:00 PM on 07/02/14 about the resident's pain medication and was told it would be delivered on the midnight run; however, she the medications did not arrive at the facility until 4:00 AM on 07/03/14. At that time, the nurse stated, Resident #35 was asleep and the nurse did not awaken the resident to administer the medication. RN #6 further stated the resident was upset and disappointed because the hospital had not given the last scheduled dose of pain medication before the resident transferred to the facility, but had assured the resident the medication would be available at the facility. Further interview revealed RN #6 did not remember if she asked the Pharmacy for a STAT delivery, and did not recall if she contacted the Director of Nursing or the resident's Physician in order to secure the medication in a timely manner. Continued interview revealed RN #6 did check the emergency box when Resident #35 requested pain medication, but the Oxycodone was not stocked at the ordered dose. The nurse acknowledged she should have taken additional steps to secure the medication, including informing the Physician to seek additional orders or a change in dose for the Oxycodone. Review of the MAR revealed the first dose of the resident's Oxycodone was not administered until 07/03/14 at 3:05 PM. Further review of the medical record revealed no documented evidence a pain assessment was completed, or any monitoring of the resident's comfort was conducted after Resident #35 requested pain medication and it was not available. An attempt to interview Resident #35 by	F 309		

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F 309	Continued From page 221 telephone, on 07/29/14 at 3:30 PM, was unsuccessful. (Resident #35 was discharged from the facility on 07/09/14). Review of the consultant Pharmacy service's information sheet revealed it included directions for obtaining medications for new residents. Continued review revealed all new orders were to be faxed to the Pharmacy, with first doses being administered from medications stocked in the facility's emergency box, if the prescribed medication was available there. Continued review revealed STAT medications (medications ordered for administration prior to the next Pharmacy delivery and not available in the emergency box) were to be called directly to the Pharmacy. Interview with the Pharmacist, on 07/31/14 at 10:45 AM, revealed Resident #35's admission medication orders were processed by the Pharmacy on 07/02/14 at 6:00 PM. He stated the medications were delivered to the facility on 07/03/14 at 4:08 AM. He stated the nurses were instructed to use the emergency box at the facility when medications were needed prior to delivery from the Pharmacy. He further stated if the medications were not available in the emergency box, the nurse should contact the Pharmacy and requested a STAT delivery. Continued interview revealed the Pharmacist could find no documentation to indicate the Pharmacy had been contacted for a STAT delivery for Resident #35 on 07/02/14, although all calls from facilities were logged by the Pharmacy staff who took the call. Interview with the DON, on 07/31/14 at 3:30 PM, revealed it was her expectation for a nurse having	F 309		

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F 309	Continued From page 222 difficulty obtaining medications from the Pharmacy to utilize the emergency box if the ordered medications were available there, and/or contact the Pharmacy for a STAT delivery. She stated if the nurse continued to be unsuccessful in obtaining the medications, he/she should call the DON for assistance, and notify the Physician for possible additional orders.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident with a catheter received the appropriate care and services to prevent infections to the extent possible for one (1) of thirty-seven (37) sampled residents (Resident #6). Observation of perineal care for Resident #6 revealed the resident's perineal area, including the "Foley" indwelling catheter, was covered with bowel movement. The staff cleaned the bowel movement with wet wipes from the skin of the	F 315	**F 315** **Immediate corrective action for residents found to be affected:** ♦ Resident #6 discharged from the facility on July 28, 2014. **Identification of other residents with the potential to be affected:** ♦ Facility currently has one resident with a Foley catheter. This resident was reviewed by the DON on August 01, 2014 and noted with no active UTI. **Measures taken to assure there will not be a recurrence:** ♦ All SRNAs have been educated by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS or WNS on the facility policy and procedure on Foley catheter care with competencies completed by the SCC or SDC. This education and competencies was performed on August 25, 2014 to September 12, 2014. Any SRNA not receiving the education or competency check off by September 12, 2014 will not be allowed to work a shift until receiving it.	

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F 315	Continued From page 223 perineal area, then changed the wet wipes to clean the "Foley" catheter tubing, which was also covered with stool. In cleaning the tubing the staff cleaned the tubing towards the vaginal area. The findings include: Review of the facility's Foley Catheter Care Policy, effective December 2010, revealed the purpose of catheter care was to prevent the spreading of bacteria from the perineal area and external catheter into the bladder, thus avoiding a possible urinary tract infection. Continued review revealed perineal care was to be performed twice daily, and consisted of washing the perineal area and the catheter with clean, warm, soapy water, followed by rinsing of the areas. Further review of the policy revealed it did not specify in which direction the catheter was to be cleaned. Review of Resident #6's medical record revealed diagnoses which included Cerebrovascular Accident (Stroke) with Left Hemiparesis (weakness on one side of the body), Decubitus Ulcers, Clostridium Difficile (C-diff) of the stool (a bacterium that could cause symptoms ranging from diarrhea to life threatening inflammation of the colon), and Escherichia Coli (E-coli) ESBL (Extended Spectrum Beta Lactamase) and VRE (Vancomycin Resistant Enterococcus) Urinary Tract Infection (UTI). ESBL and VRE are bacteria which are resistant to multiple drugs. Review of the medical record revealed laboratory data indicating a stool specimen for C-diff was collected on 06/10/14, and reported on 06/11/14 as C-diff positive. Continued review of the medical record revealed a new Physician's Order	F 315	♦ Competency checks for Foley catheter care beginning August 25, 2014 will continue weekly x 4 by the SCC, DON, ADON, SDC, WCN, MDSN, ESNS or WNS to assure ongoing compliance. ***This will continue until indicated otherwise by the QA Committee.*** ♦ Beginning August 25, 2014, the DON will monitor at daily (M-F) clinical meeting any new UTIs and outcomes of Foley catheter care competencies. **Monitoring to assure continuing compliance:** ♦ Beginning September 02, 2014, DON will bring to QA weekly x 4 and then monthly results of all audits and observations related to Foley catheter care and UTI for any further recommendations and or resolutions **Date of Compliance** ***09-27-14***	

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F 315	Continued From page 224 was received on 06/11/14 for Flagyl (an antibiotic medication) 500 milligrams (mg) three (3) times a day for ten (10) days. Continued review revealed a new Physician's Order was received on 06/29/14, for Flagyl 500 mg three (3) times a day for ten (10) days. Further review revealed a Physician's Orders on 06/30/14 to extend the Flagyl four (4) days, for a total of fourteen (14) days, related to the C-diff infection. Further review of the medical record revealed laboratory data indicated a urine specimen was collected on 06/27/14, and reported on 06/29/14 as a E-coli ESBL and Enterococcus Faecium VRE UTI. Further review revealed a Physician's Order was received on 06/30/14 for Macrobid (an antibiotic medication) 100 mg twice a day for ten (10) days, for a UTI. Observation of Resident #6's room, on 07/02/14 at 1:50 PM, revealed signage located outside the room to the right of the the door stating, "See nurse before entering, contact isolation". In addition, observation revealed a plastic bin containing gowns, gloves and shoe covers (Personal Protective Equipment, or PPE) was located beside the door outside of the resident's room. Continued observation revealed State Registered Nursing Assistant (SRNA) #16 and SRNA #17 were observed to don their gowns, shoe covers and gloves prior to entering Resident #6's room. After donning the PPE, the SRNAs entered the room to provide incontinence care for Resident #6 and to weigh the resident. Observation of the "Foley" catheter care revealed SRNA #17 cleansed stool from the perineal area, changed her wet wipe and proceeded to cleanse the catheter tubing, which was covered with bowel movement, in an upwards motion toward	F 315		

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F 315	Continued From page 225 the vaginal area. Interview with SRNA #17, on 07/02/14 at 2:45 PM, revealed she knew she was to clean the catheter from the vaginal area down towards the urinary drainage bag; however, she had inadvertently cleaned the wrong way in an attempt to clean up the stool. She stated she probably should have washed her hands and changed gloves after cleansing the perineal area as there was noticeable stool in that area, before cleaning the catheter. Interview with the Infection Control Nurse (ICN), on 07/03/14 at 4:30 PM, revealed staff were to wash their hands and use new gloves before performing catheter care. The ICN stated staff should clean catheter tubing from the vaginal area out, toward the drainage bag. She stated there were no recent inservices related to "Foley" catheter care; however, staff did receive inservices related to this on new hire orientation and yearly. She stated she randomly observed and audited catheter care and incontinence care, and if she saw a problem she would stop staff right then and correct them.	F 315		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**F 323** **Immediate corrective action for residents found to be affected:** ♦ No residents were identified to be affected	

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F 323	Continued From page 226 This REQUIREMENT is not met as evidenced by: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K". Based on observation, interview, record review, and Fire Emergency Plan and Evacuation Plan review, during the 07/03/14 survey, it was determined the facility failed to have an effective system to ensure the residents' environment remained as free of accidental hazards as possible. The facility failed to ensure a safe path to a public way for three (3) of the facility's eight (8) exits, which the facility detailed as fire evacuation exits. On 06/24/14, the facility began construction by removing the concrete pavement outside the Northwest hallway exit and the Dining room exit, and on 06/27/14 the Southwest exit door had pavement removed, affecting the safe path to a public way. Observation on 06/30/14 revealed the fire exit located at the end of the Northwest hallway had a ramp which led to a three (3) inch drop off from	F 323	**Identification of other residents that have the potential to be affected:** ♦ All residents residing on the Northwest and Southwest halls have the potential to be affected. There is no construction at this time, thus no other residents are affected. **Measures taken to assure there will not be a recurrence:** ♦ SCC in serviced Administrator and entire safety & QA committees consisting of DON, ADON, MDSN, SDC, WCN, DOA, BOM, RSM, MRM, DSM, ESD, SDC, POD and HRD/AIT, SSD, QoLD, QoLA and Chaplain. Education was provided from June 30 to July 01, 2014 and covered construction planning and continued safety of the residents, additionally the construction plan and assignments, that delineated which staff was responsible for AOC were dispersed to all departments. ♦ Construction plan initiated on June 30, 2014 included new rounds, amended exit diagrams and placement of signage in appropriate areas that included all public and employee entrances indicating which doors closed related to construction. New signs related to "DO NOT USE" were placed on the affected doors.	

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F 323	Continued From page 227 the ramp to gravel and rebar (common steel bar used in construction to reinforce concrete); the fire exit located at the Dining room exit had a concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar; and, the Southwest hallway had a ramp which led to a four and a half (4.5) inch drop off with gravel. All three (3) of the fire exits remained accessible with no signage posted at the exit doors to alert residents, staff, and visitors these exits were not accessible due to the construction. There was a total of thirty (30) beds on the Northwest hallway and thirty (30) beds on the Southwest hallway which could have potentially affected sixty (60) of the facility's one hundred and twenty-four (124) residents in the event of an emergency evacuation. The facility's failure to ensure the residents' environment remained as free of accidental hazards as was possible was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 06/30/14, and was determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at a Scope and Severity of a "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure the resident's environment remains as free of accidental hazards as possible; and each resident receives adequate supervision to prevent	F 323	♦ In-services performed for all staff from June 30 to July 01, 2014 by SCC, Administrator, DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, MRM, BOM, DOA, RSM, QoLD, QoLA, WCN, Chaplain and SSD for all staff. Education consisted of the new evacuation plan and continued safety of the residents. ♦ All residents of BIMS 8 or greater were informed of the construction and alternate evacuation routes and signs from June 30 to July 01, 2014 by the SSD and QoLD. ♦ Responsible parties of resident with BIMS less than 8 were notified of the construction and temporary evacuation routes from June 30 to July 01, 2014 by the Chaplain and DOA. ♦ Signs were placed on main entrance and employee doors that construction is in progress on June 30, 2014 by the HRD/AIT and POD. ♦ All new temporary diagrams were created for southwest hall, northwest hall, dining room, dietary services and laundry area by the POD and posted on all temporary alternate evacuation routes on June 30, 2014. ♦ Medical director was notified on June 30, 2014 by the DON and is in agreement with steps taken.	

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F 323	Continued From page 228 accidents. The findings include: Review of the facility's, "Disaster Preparedness" Manual, dated January 2005, revealed the fire safety procedure plan, stated in preparing for an evacuation after the fire alarm was sounded, staff was to first check the primary exit route. If it was clear and safe, they were to use that exit if evacuation was ordered. Review of the facility's, "Fire Safety Procedures Orientation Training", undated, revealed under the "evacuation" section, staff was to first check the primary exit route, if it was clear and safe, use that exit if evacuation was ordered. Review of the facility's Map on 06/30/14 at 5:15 PM, posted in the dining room, revealed arrows leading from the dining room to the outside exit as an exit route from the dining room. However, observation on 06/30/14 at 5:15 PM, of the Dining room fire exit door revealed a concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar (common steel bar used widely in construction to reinforce concrete). Review of the facility's "North Nursing Department Fire Emergency Guidelines" revealed staff was to check the primary exit route, if blocked use the secondary route. Continued review revealed staff were to report to the grassy area south of the parking lot on the south side of the building, and the sidewalk in front of the building. Review of the facility's Map on 06/30/14 at 5:20 PM, posted across from the nurse's station on the	F 323	♦ All staff has been educated on environmental hazard identification by the SCC, Administrator, DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, MRM, BOM, DOA, RSM, QoLD, QoLA, WCN, Chaplain and SSD. This education was performed on August 25, 2014 to September 12, 2014. Any staff member not educated by September 12, 2014 will not be allowed to work a shift until being educated. ♦ Beginning August 02, 2014 the POD or POD Assistant (PODA) will conduct environmental hazards rounds weekly x4 weeks to identify any potential hazards and forward results to the Administrator. After the first 4 weeks, these will be conducted monthly and forwarded to the Administrator. ♦ *Stakeholders were notified of the construction being completed and reverting back to the original evacuation plan on August 15-25, 2014. All stakeholders not completing this education were sent letters on August 25, 2014 notifying them of the change in plan. The individuals responsible for notifying the staff were HRD/AIT, PODA, POD, QoLA, ESNS, WNS, DOA, DON, Chaplain, RSM, ADON, MDSN, MRM, DSM, ESM, BOM, QoLD, SSD, SDC, or WCN.*	

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F 323	Continued From page 229 north unit, revealed an exit route for the Northwest hallway with arrows pointing towards the exit door at the end of the Northwest hallway leading outside. However, observation on 06/30/14 at 5:20 PM revealed the fire exit at the end of the Northwest hallway had a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar. Review of the facility's, "South Nursing Department Fire Emergency Guidelines", undated, revealed staff was to check the primary exit route, if blocked use the secondary route. Review revealed staff were to report to the grassy area south of the parking lot on the south side of the building, and the sidewalk in front of the building. Review of the facility's Map on 06/30/14 at 5:24 PM, posted across from the nurse's station on the south unit, revealed an exit route for the Southwest hallway with arrows pointing towards the exit door at the end of the Southwest hallway leading outside. However, observation on 06/30/14 at 5:24 PM revealed the fire exit door at the end of the Southwest hallway had a ramp which led to a four and a half (4.5) inch drop off with gravel and rocky uneven surface. Further observation on 06/30/14 at 5:15 PM, 5:20 PM and 5:25 PM revealed there was no signs posted at the Southwest, Northwest, and Dining room exits to alert staff, residents, and visitors these exits were not accessible due to the construction. Interview with the Director of Plant Operations, on 06/30/14 at 2:20 PM, revealed construction began on 06/24/14 with the removal of the	F 323	**Monitoring to assure continuing compliance:** ◆ Beginning August 06, 2014 the POD or PODA shall report all construction activity, plans and results of environmental hazards audits to the QA committee weekly x4 and then monthly for any further recommendations and resolutions. **Date of Compliance** ***09-27-14***	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 230 concrete pavement outside of the Northwest Hallway and the Dining room exit and on 06/27/14 the concrete pavement was removed outside the Southwest exit door. Continued interview revealed these three (3) exits were not safely accessible in case of an emergency evacuation. Observation of the Southwest hallway exit door, at the time of the interview, revealed the door was access-controlled with magnetic locks and could be released with a manual release device and was operational. Further observation revealed when the green button by the door was pushed, a beeping noise would start and the door would disengage and could be opened within fifteen (15) seconds. Observation on 06/30/14 at 5:15 PM of the dining room fire exit door and at 5:20 PM of the Northeast hallway fire exit doors revealed when the green button by the door was pushed, a beeping noise would start and the door would disengage and could be opened within fifteen (15) seconds. Interview with State Registered Nursing Assistant (SRNA) #1, on 06/30/14 at 3:16 PM, revealed she would have used the Northwest, Southwest, and dining room exits to the outside if an emergency arose which required residents to be evacuated. She stated she was aware of construction going on; however, as far as she knew these exits were not affected. Interview with Housekeeper #1, on 06/30/14 at 3:20 PM, revealed she would use the Northwest, Southwest, and dining room exits to the outside in the case of an emergency evacuation because she had not been told she could not use the exits.	F 323		

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F 323	Continued From page 231 Interview, on 06/30/14 at 5:01 PM, with the Social Service Director (SSD) revealed she had sent out a letter to inform families of the construction; however, she did not know the date construction was to start at the time she sent the letter. She viewed the Northwest, Southwest, and dining room exits and stated the residents would not be able to exit these exits due to construction, and this was a safety concern. Review of the letter sent to families by the SSD, revealed a date of 02/19/14, which detailed the renovation at the facility would include fresh paint, flooring, furniture, an expanded gym and the addition of private rooms. However, there was no documented evidence the letter addressed any construction taking place outside the building. Interview, on 06/30/14, at 5:15 PM, with Licensed Practical Nurse (LPN),#4 revealed was not aware these exits could not be used until that day, 06/30/14. Interview, on 06/30/14 at 5:17 PM, with the second shift Supervisor/Registered Nurse (RN) #5 revealed on 06/27/14 she was told not to use the exits to the back of the building, but she thought construction had already began at that time. She stated she did not formally inservice staff not to use those exits; however, did verbally tell some of the staff. Interview, on 06/30/14 at 5:30 PM, with Housekeeper #2 revealed his supervisor told him there was construction in the back of the building; however, he was unaware there was gravel and a drop off at the back exit doors, which included the Northwest, Southwest and dining room doors to the outside. He stated he was not aware of an	F 323		

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F 323	Continued From page 232 alternate evacuation plan. Interview, on 06/30/14 at 5:50 PM, with SRNA #4 revealed she became aware there was construction going on "last week" when she saw a piece of construction machinery. She stated she had seen the gravel at the back of the building; however, was unaware there was a drop off from the back exit doors. She stated she was confused because a nurse had told her she could use the back exit doors for an emergency exit; but, the Maintenance Director had told her those exits were inaccessible. Interview, on 06/30/14 at 5:52 PM, with LPN #1 revealed she was not educated until that day, 06/30/14, in regards to not using the Northwest and Southwest exit doors due to construction. Observation of the back side of the building with LPN #1 at the time of the interview, revealed she indicated staff would not be able to take residents out the three (3) exits involved (Northwest, Southwest and dining room exits), and it would be a safety issue for residents to try to evacuate them from those exits. Interview, on 06/30/14 at 5:55 PM, with SRNA #3 revealed she was unaware of the construction taking place in the back of the building until that day, 06/30/14. Interview, on 06/30/14 at 7:30 PM, with LPN #3 revealed she knew there was construction going on, but she had received no new information related to a new evacuation plan, and was unaware of the exits which were inaccessible due to construction. Interview, on 06/30/14 at 5:17 PM, with the	F 323		

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F 323	Continued From page 233 Assistant Director of Nursing (ADON)/Unit Manager for the South hall revealed the doors at the back of the building, including the Northwest, and Southwest doors were inaccessible due to the construction. Continued interview revealed if staff were unaware of the blocked exits, this could be a safety issue if there was a fire. Interview, on 06/30/14 at 5:05 PM, with the Director of Nursing (DON) revealed she was told in the "Stand Up Meeting" the morning of 06/17/14, there would be construction to start on 06/18/14, which included repairing concrete; however, the construction was delayed and started on a later date. She stated, in the same meeting they were told to stay clear of the exit doors to the Northwest and Southwest hall exits because the sidewalks were being replaced outside those doors. The DON stated there were two (2) exits in the front of the building, an exit by the therapy department, and also the Northeast and Southeast hallway doors to the outside that could be used in the case of an emergency evacuation. However, she indicated she had not been educated as to the alternate routes to use for emergency evacuation. She stated the Staff Development Nurse inserviced staff related to the construction; but, she was unsure if all staff had been inserviced and instructed to use the alternate routes for emergencies. She stated staff would be unable to get residents' wheelchairs out the exits where the construction was taking place. She indicated these exits would be dangerous for people at risk for falls, and also for residents who were confused and exit seeking. According to the DON, this made it important to ensure staff were aware of which exits led to the construction zones.	F 323		

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F 323	Continued From page 234 Interview with the Staff Development Nurse (SDN), on 06/30/14 at 5:30 PM, revealed she was told by the Director of Plant Operations during a morning "Stand Up Meeting", there was construction going on outside and the facility was putting new concrete on the driveway out back. She stated she was told there would be construction workers with machines and they could not use the exits to the back of the building including the dining room exit. Continued interview revealed the DON had asked her to let staff know which doors would be inaccessible due to construction; however she was not told who to inservice and was not told exactly what the new evacuation routes would be. She stated she did an informal verbal inservice at the last "Town Hall Meeting" which was done on payday, Friday on 06/20/14, for the staff who picked up their checks that day. The SDN stated she told staff present, the doors which would be inaccessible due to construction would be the Southwest door, the dining room door and the kitchen door. However, she was unaware there was construction near the Northwest exit door and did not inservice staff related to that door. She stated she also told staff which doors they could use for evacuation of residents. However, she stated she was unaware of the date of the inservice, and was unable to submit the inservice or signatures of staff present from the inservice. Interview with the Administrator, on 06/30/14 at 7:00 PM, revealed she started at the facility on 05/15/14, and was told by the previous Administrator on that date there would be construction which included replacing damaged pavement on the west or back side of the building. She stated during the "morning meetings" she discussed with the managers the	F 323		

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F 323	Continued From page 235 construction consisted of tearing up the concrete and re-pouring the concrete at the back of the building; however, they did not discuss the safety aspects related to the construction. She stated no formal education was provided to staff regarding which doors were affected by the construction and which doors were to be used for alternate routes. Further interview with the Administrator and previous Administrator on 07/01/14 at 12:00 PM, revealed residents did not go outside unsupervised and never went past the front porch. However, they stated there was confused and/or exit seeking residents in the building, and residents who were at risk for falls and this would be dangerous if they were to exit on to the construction zone. Continued interview revealed there was a wanderguard system in place to alert staff if a resident, at risk for elopement wearing a wanderguard device, was attempting to exit the building. They stated the wanderguard system affected the front lobby doors and the south side door, but did not affect the Northwest and Southwest Hallway exit doors or the dining room exit door. Further interview revealed once the green button was pushed by the three (3) exit doors leading to the construction zone, there would be a beeping noise and the doors would open within fifteen (15) seconds. They revealed if there was a fire, all the exit doors would disengage and open when pushed. Review of the facility's, "Residents at Risk for Elopement Risk", revealed sixteen (16) residents were at risk in the facility. Review revealed three (3) residents resided on the Southwest Hallway and three (3) residents who resided on the Northwest Hallway. In addition, review of the	F 323		

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F 323	Continued From page 236 facility's Roster Matrix revealed nineteen (19) residents who were identified at risk for falls. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following: 1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating "DO NOT USE" were also placed on the affected doors. 2. Inservices were initiated on 06/30/14 and	F 323		

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F 323	Continued From page 237 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff. 3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14. Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified. 4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the	F 323		

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F 323	Continued From page 238 Maintenance Director to inform all visitors that "Construction is in progress". Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all "temporarily closed" evacuation exits that stated, "STOP-DO NOT USE" by the Maintenance Director on 06/30/14. 5. The Medical Director was notified of the IJ 07/01/14 by the DON. 6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to "STOP-DO NOT USE". The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14. 7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors "Construction is in process". The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all "temporarily closed"	F 323		

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F 323	Continued From page 239 evacuation exits saying "STOP-DO NOT USE" remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed. 8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct "spot checks" of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator. 9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the	F 323		

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F 323	Continued From page 240 Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use. The State Agency validated the implementation of the facility's AOC as follows: 1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM. Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction. 2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, "due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice". Continued review of the education material revealed the alternate evacuation plan was included, as well as, the	F 323		

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F 323	Continued From page 241 questions for the post test to ensure competency and understanding. Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person. Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency. 3. Review of the education documents revealed	F 323		

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F 323	Continued From page 242 all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes. Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14. Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans. Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any	F 323		

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F 323	Continued From page 243 questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education. 4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged. Observation, on 078/02/14 at 11:32 AM, revealed signs stating "STOP-DO NOT USE" were posted on the "temporarily closed" evacuation exits. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM. 5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14. 6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided	F 323		

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	185446	A. BUILDING _____ B. WING _____	08/01/2014

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F 323	Continued From page 244 insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director. 7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the "STOP-DO NOT USE" signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log. 8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire. Interview with the Administrator on 07/02/14 at	F 323		

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F 323	Continued From page 245 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing "spot checks" of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her. 9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator. Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party.	F 323		
F 353 SS=K	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,	F 353	**F 353** **Immediate corrective action for resident affected:** ♦ ~~No residents were identified~~ ~~Please *refer to Ftags 166, 224, 225 and 226 for specific residents and corrective actions taken.*~~	

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F 353	Continued From page 246 and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75	F 353	***Resident #8, 16, 17, 32, 33, and 36 have all had grievances completed July 23 to July 25, 2014 by SSD, Administrator, DON, MRM, QoLA, ESD, DOA, MDSN, HRD/AIT and QoLD to include follow-up and resolution reported to all appropriate state agencies.*** ♦ ***On July 23 to July 25, 2014, resident #26 had investigation opened related to allegations of neglect and initial reports were completed as well as 5 day follow-up reports to all appropriate state agencies. SSD met with the residents to assess for any issues or complaints.*** **Identification of Other Residents with the Potential to be affected** ♦ All residents with BIMs of 8 or above were interviewed on July 23 to July 25, 2014 by SSD, HRD/AIT, QoLD, QoLA, MRM, Chaplain, BOM, DOA, ADON, SDC, SCC and ESNS with any concerns voiced taken through the grievance process for follow-up and resolution. ♦ All residents with a BIMS below 8, Responsible Parties, POA or Guardian were interviewed on July 23 to August 04, 2014 by SSD, HRD/AIT, DOA, MRM, Chaplain, BOM, ABOM, ESD, DSM, SCC, ADON, QoLA and QoLD with any concerns taken through the grievance process for follow-up and resolution. Anyone unable to contact were sent certified letters on July 29, 2014.	

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F 353	Continued From page 247 Administration (F-490) all at a Scope and Severity (S/S) of a "K". Based on interviews, record reviews and review of the facility's Daily Staffing Sheets and time clock punches, during the 08/01/14 survey, it was determined the facility failed to have sufficient staffing to ensure residents' care needs were met for residents residing on the facility's two (2) units as evidenced by residents' complaints and concerns of their call lights not being answered timely, and their request for assistance not being provided for seven (7) of thirty-seven (37) sampled residents (Residents #8, #16, #17, #26, #32, #33 and #36), and staff's reports of being short staffed on the night shift. Resident #26 rang his/her call light on 07/03/14, at approximately 5:30 AM for incontinence assistance; however the two (2) State Registered Nursing Assistants (SRNAs), SRNA #19 and SRNA #21, working on the South Unit where the resident resided had a conflict and did not work together to provide care for residents. SRNA #19 did not get SRNA #21 to assist her with Resident #26 because of the conflict, therefore Resident #26 had to wait until approximately 7:45 AM, for assistance to get cleaned up. Additionally interviews with residents revealed their call lights were not answered in a timely manner and their request for assistance was not provided in a timely manner due to the facility's staffing. Also, interviews with staff revealed they were short staffed on night shift, and could not always get resident care provided and call lights answered in a timely manner. After becoming aware of this information on 07/03/14, the facility initiated an investigation and	F 353	◆ 100% of the resident population received head to toe assessments on July 23 to July 28, 2014 by the DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses. **Measures taken to assure there will not be a Recurrence** ◆ All staff will be in serviced on July 23 to July 30, 2014 by the SDC, SCC, HRD/AIT, SSD, ESNS, DON, ADON, WCN, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD or Chaplain related to Grievance policy and procedure. Re-education was initiated on August 25, 2014 and was completed by September 12, 2014. ◆ Education has been provided by the SCC on July 23 to July 28, 2014 to all department heads related to following the grievance policy and procedure and assuring all concerns are investigated and follow-up is completed timely. ◆ Any staff member not receiving the education by September 12, 2014 will not be allowed to work a shift until the education has been provided by the SDC, SCC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain. ◆ Beginning September 12, 2014 Residents and families attending care plan conferences shall be asked by the SSD, MDSN, QoLD or Licensed Nurse if there have been any concerns and if grievance	

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F 353	Continued From page 248 identified a conflict between the two (2) SRNAs normally scheduled on the South Unit who didn't work together to provide care. However, the facility failed to address the interviewed residents' concerns with night shift and failed to address the conflict between the two (2) SRNAs assigned to the unit on the night shift which impacted resident care and left residents at risk for further neglect. (Refer to F-225 and F-226) The facility's failure to have sufficient staffing to ensure residents' care needs were met for residents was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 07/25/14, and was determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure sufficient staffing to ensure residents' care needs are met for all residents. The findings include: Review of the Census and Condition (CMS-672) Form dated 06/30/14, revealed the facility had a total census of one hundred and six (106) residents of the one hundred and twenty-four (124) total certified beds. Review of the Form	F 353	process has been initiated and followed. If resident or responsible party does not attend the care plan conference the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain. shall attempt to contact via phone x3 for response. ♦ The Administrator will be responsible for monitoring the grievance process to be assured all grievances have been completed per the policy and procedure. ♦ Beginning August 02, 2014, five audits are being completed daily across all shifts by SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, Administrator, Chaplain or Licensed Nurse related to call light observations to assure answered timely and patient care needs met. This will be ongoing until instructed otherwise by QA Committee. ♦ Beginning August 02, 2014 five resident interviews daily of residents with BIMS of 8 or above by the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator, Chaplain or MOD to address call lights and any care issues. This will be ongoing until instructed otherwise by QA Committee.	

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F 353	Continued From page 249 revealed: seventy-six (76) residents required one (1) to two (2) staff assist with transfer; twenty-five (25) residents were totally dependent on staff for transfers; ninety (90) residents required assist of one (1) to two (2) staff for toileting; sixteen (16) residents were totally dependent on staff for toileting; eighty-six (86) residents required one (1) to two (2) staff for dressing; and, twenty (20) residents were totally dependent on staff for dressing. Review of the facility's bed listing, floor map and Resident Census for the North and South Units from 06/30/14 through 07/02/14 revealed the South Unit was a sixty (60) bed unit with a census of fifty-one (51) residents; and, the North Unit was a sixty-four (64) bed unit with a census of fifty-five (55) residents during that timeframe. Interview, on 07/23/14 at 5:49 PM, with the Director of Nursing (DON) revealed the facility did not have a policy related to staffing. She stated the Staff Development Coordinator (SDC) completed the daily scheduling of staff, and if there were call-ins the SDC or Evening Shift Supervisor attempted to provide coverage. The DON stated staff was instructed to call her or the Assistant Directors of Nursing (ADONs). She stated she did not get the Daily Assignment Sheets and did not review them, and was not always aware of the actual staffing for the previous day. Continued interview with the DON revealed during the daily clinical meeting the day's staffing was discussed. Per interview, the DON stated for night shift staffing there was no minimum, and the facility staffed four (4) nurses and four (4) State Registered Nursing Assistants (SRNAs), two (2) nurses and two (2) SRNAs on each of the facility's two (2) units, for a total of	F 353	♦ DON, ADON, SDC and HRD/AIT were in serviced related to staffing protocols **(*Bluegrass* Care and Rehabilitation Center utilizes the ABS (Acuity Based Staffing) plan generated by CMS (Center for Medicare/Medicaid Services). Three (3) days staffing is reviewed in the morning stand up meeting (yesterday's, today's and tomorrow's with Sunday's being included on Friday) M-F. Copies of the three (3) days of staffing sheets will be provided to the DON, ADON, HR Director and Administrator for review in order to review previous days staffing as well as assist in any discrepancies for future schedules)** and coverage by SCC and Administrator on August 30, 2014. ♦ HRD/AIT, MRM, SCC, SDC, ESNS, or WNS inserviced nursing staff on August 31 to September 12, 2014 relative to new staffing protocols, how and to whom to go with conflict as well as education on the corporate hotline, attendance policy and conflict management. Any stakeholder not inserviced by September 12, 2014 will not be permitted to return to work until completed. ♦ Beginning August 31, 2014 and continuing for 4 weeks, HRD/AIT is interviewing nursing staff relative to existing teamwork, existing conflict, care issues and stakeholder neglect or abuse. This process will continue until instructed otherwise by the QA Committee.	

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F 353	Continued From page 250 eight (8) staff at night. She stated staff should call her if there were not two (2) nurses and two (2) SRNAs on each unit during the night shift. Review of the facility's "Attendance" policy, undated, revealed staff were to provide the Supervisor with at least two (2) hours advance notice of his/her inability to report for his/her assigned shift". Interview, on 07/31/14 at 7:14 PM, with the SDC revealed the facility's process was "acuity based" which meant that staffing for the day was based on what activities were occurring in regards to admissions and discharges, whether residents were on intravenous (IV) antibiotics and other such issues. However, she stated she had a "budget" of total nursing staff hours to use, so staffing "basically" always was: for day shift (7:00 AM to 3:00 PM) three (3) nurses per unit, with two (2) as the minimum, and a "goal" of five (5) SRNAs, with four (4) as the minimum; evening shift (3:00 PM to 11:00 PM) three (3) nurses per unit, with two (2) the minimum, and three (3) to four (4) SRNAs minimum; and for night shift (11:00 PM to 7:00 AM) two (2) nurses per unit and two (2) SRNAs. Continued interview with the SDC revealed the day's staffing was reviewed in the morning "clinical" meeting, and call-ins were discussed. She stated if she became aware of staffing being short on a shift she tried to get coverage, or have staff from the previous shift stay over and staff from the next shift come in early. The SDC stated there had been a "problem" with communication on the evening and night shifts related to staffing, and since hiring the Evening Shift Supervisor it was better on that shift.	F 353	♦ Beginning September 12, 2014, staffing will be reviewed daily by the Administrator, DON, ADON, SDC, ESNS, WNS, MOD or HRD/AIT the previous days staffing, current day and next day to assure appropriate coverage has occurred. ♦ An on call schedule has been developed on August 11, 2014 for the DON, ADON, SDC WCN, ESNS and WNS to assure assistance with coverage for call off situations. ♦ A MOD program ***(this program is not to be confused with the WNS, This program is comprised of non-clinical managers that will be assigned to weekends to assist the WNS in whatever means possible to secure staffing, etc. or to assist with nonclinical services (passing ice, making beds, etc.) if and when needed)*** has been initiated on August 23, 2014 utilizing nonclinical managers consisting of HRD/AIT, DOA, Chaplain, MRM, QoLD, QoLA, DSM, ESD, POD, BOM and SSD for week end assistance with facility and schedule management as needed. **Monitoring changes to assure continuing compliance:** ♦ Beginning September 02, 2014, the DON will report to QA committee weekly x 4 and them monthly all results of audits, interviews, and observations for any further recommendations or resolutions. **Date of Compliance** **09/27/14**	

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F 353	Continued From page 251 However, she stated the 11:00 PM to 7:00 AM shift was "still" a problem, as sometimes she did not get the call-ins for that shift until she came in the next morning. The SDC indicated six (6) staff on night shift would not be acceptable; and if there was only one (1) SRNA on a unit at night it would be "difficult" to provide the care residents required. Review of the June 2014 Daily Staffing Sheets and Time Clock Punches for the 11:00 PM to 7:00 AM shift and the facility's daily resident census revealed: on 06/05/14 seven (7) staff worked the shift, one (1) nurse and two (2) SRNAs on the South Unit with a resident census of forty-eight (48), and two (2) nurses and two (2) SRNAs on the North Unit with a census of fifty-four (54); on 06/06/14 five (5) staff was present in the facility after 3:00 AM, two (2) nurses assigned on the South Unit, with a resident census of forty-eight (48), and one (1) nurse and two (2) SRNAs on the North Unit with a census of fifty-five (55); on 06/08/14, seven (7) staff worked the shift, two (2) nurses and one (1) SRNA on the South Unit with a resident census of forty-nine (49), and two (2) nurses and two SRNAs on the North Unit with a census of fifty-five (55); on 06/09/14, seven (7) staff worked the shift, two (2) nurses and two (2) SRNAs on the South Unit with a resident census of fifty (50), and one (1) nurse and two (2) SRNAs on the North Unit with a census of fifty-five (55); on 06/13/14, seven (7) staff was present, two (2) nurses and two (2) SRNAs on the North Unit with a census of fifty-eight (58) and one (1) nurse and two (2) SRNAs on the South Unit with a census of fifty-one (51); on 06/14/14, seven (7) staff worked, one (1) nurse, one (1) SRNA/Kentucky Medication Aide (KMA) and two (2) SRNAs on the North Unit with a census of fifty-seven (57), and	F 353		

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F 353	Continued From page 252 one (1) nurse and two (2) SRNAs on the South Unit with a census of fifty-one (51); on 06/15/14, seven (7) total staff worked the shift, two (2) nurses and two (2) SRNAs on the South Unit with a resident census of fifty-one (51), and two (2) nurses and one (1) SRNA on the North Unit with a census of fifty-six (56); and, on 06/20/14, six (6) staff were working the shift, one (1) nurse and two (2) SRNAs on the North Unit with a resident census of fifty-six (56), and one nurse and two (2) SRNAs on the South Unit with a census of fifty-one (51). Review of the facility's Roster Sample Matrix, provided by the facility on 06/30/14, revealed the South Unit had forty (40) residents assessed to be incontinent of bladder and/or bowel, and thirty-eight (38) residents assessed to be incontinent of bladder and/or bowel on the facility's North Unit. Interview, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, with SRNA #19 revealed she worked the night shift on the South Unit and at times had been the only SRNA assigned to care for residents on the whole unit. She reported at least one (1) night a week she had to work as the only SRNA on the whole unit. SRNA #19 revealed when she worked as the only SRNA on the unit she could only complete two (2) rounds all night, instead of the every two (2) hour rounds that were required. She stated she could not complete the last round on residents who required two (2) person assist as the nurses couldn't help her if she was the only SRNA on the unit. She stated there had been a few times when there was only one (1) nurse and one (1) SRNA working on the unit; however, this had not happened often. Per interview, SRNA #19 stated	F 353		

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BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 253 she had heard there were only two (2) SRNAs in the "whole building" a few nights before. SRNA #19 stated "Administration" know "we need more help"; however, she indicated nothing had been done. SRNA #19 revealed she had not been able to perform incontinence care on Resident #26 and Resident #29 during her last rounds on 07/03/14, as those two (2) residents were two (2) person assist. She stated there was a conflict between her and SRNA #21 and she had not requested SRNA #21's assistance on 07/03/14 due to the conflict. Per interview, she stated she had informed the nurses and they were aware of the conflict; however, nothing had been done so far. SRNA #19 stated there were seven (7) residents who required two (2) person assist on the Southeast hall, of the South Unit she worked on. Interview, on 07/25/14 at 2:48 PM, with SRNA #6, a 7:00 AM to 3:00 PM SRNA, revealed she couldn't always get residents call lights answered as fast as residents needed them answered during her shift, and it was worse on the night shift. She indicated she sometimes came in earlier due to the staffing on night shift. Interview, on 07/24/14 at 9:48 PM, with SRNA #22, a night shift SRNA, revealed she had worked on the North Unit as the only SRNA "several times" before. She stated when there was only one (1) SRNA working the whole unit it wasn't fair to the residents or the SRNA. According to SRNA #22, when the unit was staffed like that, all she could do was try to get all the residents changed, and if residents rang their call lights they would have to wait, if she was in another resident's room and the nurse was busy. Continued interview with SRNA #22 revealed	F 353		

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F 353	Continued From page 254 during the times when she was the only SRNA working the unit residents would want to get up out of bed in the morning and she would have to tell them she couldn't get them up. She stated one (1) SRNA could not take care of fifty (50) to sixty (60) residents by themselves; and could only complete about two (2) rounds the whole night, instead of the every two (2) hour rounds. She stated when she worked as the only SRNA on the unit sometimes residents would have to lay wet and soiled, and she couldn't turn residents every two (2) hours like she was supposed to. SRNA #22 reported it wasn't fair to the "poor" residents to be cared for like that, and she would not want her grandparents "treated like that". The SRNA stated she knew SRNA #19 had worked by herself on the South Unit before. Per interview, SRNA #22 stated there had been one (1) time there was only one (1) nurse, one Certified Medication Aide (CMA)/SRNA and herself working the whole unit, and indicated she thought it was 06/06/14. Review of the Daily Staffing Sheets and Time Clock Punches for 06/06/14, on the 11:00 PM to 7:00 AM shift, revealed seven (7) staff present in the entire facility, one (1) SRNA worked the 3:00 PM to 11:00 PM and stayed over until 3:00 AM. Further review of the Staffing Sheets and Time Clock Punches revealed after 3:00 AM, only six (6) staff were present in the facility, four (4) nurses and two (2) SRNAs, (two (2) nurses and an SRNA on each unit). Further interview with SRNA #22 revealed that night was "crazy", and she had called the "on-call" administrative person, Registered Nurse (RN) #4/Assistant Director of Nursing (ADON), who said she would try to get SRNA #22 some help; however, no one showed up to help. She stated also that night on the South Unit there were no SRNAs after 3:00 AM, when the 3:00 PM to 11:00	F 353		

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F 353	Continued From page 255 PM SRNAs who had stayed over to help left to go home. In addition, she stated staffing was a problem at times on both units. SRNA #22 stated all the day shift nurses were aware of the times she had worked by herself on night shift. Interview, on 07/29/14 at 3:20 PM, with SRNA #31 revealed "lately" the facility had been "short staffed", and it depended on staffing on how long it was for residents' call lights to be answered. SRNA #31 stated if they worked "short staffed" it was "harder" to get the work done. According to SRNA #31, sometimes night shift was staffed with only one (1) SRNA on a unit, and staff would have to come in early or stay over to help the night shift SRNA out, "because obviously" they couldn't get all their work done by themselves. In addition, he stated when they worked "short staffed" they couldn't get everything documented in the "Kiosk", (the facility's computer system for SRNAs). SRNA #31 indicated "a lot" of residents complained about their call lights not getting answered in a timely manner, and reported it could take five (5) minutes to fifteen (15) minutes for the SRNAs to be able to answer a call light. Interview, on 07/30/14 at 2:55 PM, with SRNA #18 and SRNA #20 revealed "there could be and should be more" staff, and there should be "staffing ratios" to ensure residents received the care they needed. The SRNAs indicated staff was "short" on "pretty much every shift", and SRNAs had to "hit the ground running" to get everything done. They stated they were aware of there being only one (1) SRNA on night shift at times on a unit. The SRNAs reported day shift staff had to come in early to help out and evening shift would stay over to help out because only one (1) SRNA couldn't care for all the residents on the	F 353		

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F 353	Continued From page 256 unit without help. Interview, on 07/25/14 at 9:17 AM, with Licensed Practical Nurse (LPN) #9, a 7:00 PM to 7:00 AM nurse, revealed she recalled one (1) time in June when SRNA #22 had to work by herself on the North Unit. Review of the Time Clock Punches for 06/06/14 revealed on the 11:00 PM to 7:00 AM shift, only six (6) staff present in the facility after 3:00 AM, four (4) nurses and two (2) SRNAs, one of which was SRNA #22. Continued interview with LPN #9, revealed if the nurses didn't help with providing direct care when there was only one (1) SRNA, they wouldn't be able to get their rounds completed, it would be "tough". LPN #9 also stated if there was only one (1) SRNA they wouldn't be able to get residents up for the morning. Interview, 07/25/14 at 1:35 PM, with Registered Nurse (RN) #8, a 7:00 PM to 7:00 AM nurse, revealed there was still a problem with not enough SRNAs in the facility, and reported the facility was "short on them often". RN #8 stated night shift staffing was supposed to be two (2) nurses and two (2) SRNAs on each of the two (2) units, but there were times when there was only one (1) nurse with two (2) SRNAs, or two (2) nurses with only one (1) SRNA on a unit. She stated when the staffing was like that it was hard to get all the work done, and if residents rang their call lights they would have to wait, and at times it might be fifteen (15) to thirty (30) minutes or longer. She stated once when she had been the only nurse, she had refused to "clock in" to work until another nurse was found to help her which did happen and she worked. Review of the Time Clock Punches for 06/05/14, on the 11:00 PM to 7:00 AM shift, revealed RN #8 was one (1)	F 353		

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F 353	Continued From page 257 of only two (2) nurses working the shift for that day in the facility with only three (3) SRNAs. Review of the 06/20/14 Time Clock Punches revealed RN #8 was one (1) of only two (2) nurses working that day, with four (4) SRNAs. Continued interview with RN #8 revealed the facility census had been about full that night and the acuity of the residents had made her feel not safe being the only nurse. She stated the SRNAs worked with only one (1) SRNA at night about "every other week". RN #8 stated when that happened it was "pretty hard", and the nurses helped the SRNAs as they could to provide resident care during rounds. According to RN #8, when there was only one (1) SRNA on the unit they couldn't get residents who wanted to get up in the morning up, and that made her feel bad for the residents. However, she stated the work was "too overwhelming" for the SRNAs in the mornings as the nurses had to pass medications and could not help them out as much. She stated residents had to wait for day shift to come in at 7:00 AM to get them up. Further interview revealed residents might also have to "wait a little while" to get their call lights answered, especially in the early morning, between 5:00 AM and 7:00 AM it would take longer. Interview, on 07/24/14 at 7:19 PM, with RN #5/Evening Supervisor, who worked 3:00 PM to 11:00 PM, revealed the staffing for 11:00 PM to 7:00 AM, was supposed to be two (2) nurses and two (2) SRNAs on each of the facility's two (2) units. However, she stated she was aware of times when there were only three (3) nurses in the facility on the night shift but, she stated there was "not a big med pass in the morning", and indicated it was okay. She indicated she attempted to get coverage if there were call-ins.	F 353		

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F 353	Continued From page 258 Interview, on 07/26/14 at 10:09 AM, with RN #6 revealed on the North Unit during the month of June she was aware of one (1) SRNA having to work the entire unit by herself for two (2) nights in a row. Review of the Time Clock Punches for 06/19/14 and 06/20/14 revealed on the 11:00 PM to 7:00 AM shift, SRNA #21, who was sometimes pulled to work the North Unit, worked those nights as one (1) of only three (3) SRNAs in the entire facility for that shift. She stated the nurses assisted as well as they could helping do rounds with the SRNAs to get residents cared for, until 5:00 AM when they started their medication pass. RN #6 stated the SRNAs on the South Unit also helped out those two (2) nights, as they could, but had their own residents to care for. After receiving a complaint regarding the lack of care provided by night shift staff on 07/03/14 the facility initiated an investigation. Review of the investigation report dated 07/03/14 through 07/07/14, revealed interviewable residents had been questioned regarding the care received on night shift, 11:00 PM to 7:00 AM, and Resident #16, Resident #8, Resident #17, Resident #26, Resident #36, Resident #32 and Resident #33 all expressed concerns regarding care on night shift. 1. Review of Resident #26's medical record revealed the facility admitted the resident on 07/23/12, with diagnoses which included Depressive Disorder, Difficulty Walking, Muscle Weakness, Muscle Disuse Atrophy and Abnormality of Gait. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #26 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which	F 353		

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F 353	Continued From page 259 indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #26 as requiring: extensive physical assistance of two (2) staff with his/her Activities of Daily Living (ADLs) of bed mobility, transfers and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder. Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed on 07/03/14, during the night shift he/she had "pooped" on himself/herself. Resident #26 stated he/she had requested assistance from SRNA #19, but the SRNA had not helped the resident. Resident #26 stated at times he/she had waited for over an hour for staff to answer his/her call light before. Resident #26 reported he/she had problems with getting staff to answer his/her call light on the night shift, 11:00 PM to 7:00 AM, and the day shift, 7:00 AM to 11:00 PM. 2. Review of Resident #32's medical record revealed the facility admitted the resident on 05/24/13, with diagnoses which included a History of Falls, Stroke with Right Hemiplegia (Paralysis of one side of the body), Mental Disorder and Seizure Disorder. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14) which indicated no cognitive impairment and the resident was interviewable. Continued review of the MDS Assessment revealed the facility assessed Resident #32 to require extensive assistance of two (2) staffs physical assist with most of his/her ADLs including transfers, bed	F 353		

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F 353	Continued From page 260 mobility and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of urine and always continent of bowel. Review of Resident #32's Comprehensive Care Plan, dated June 2014, revealed the resident was care planned for ADL self care deficit related to his/her diagnoses which included History of Stroke with Right Hemiplegia, and for the potential for complications related to his/her incontinence of bladder. Interview, on 07/03/14 at 2:14 PM, with Resident #32 revealed no one answered when he/she pressed his/her call light. Resident #32 stated he/she became incontinent and had to wait while sitting in his/her urine for assistance after ringing the call light. Additional interview, on 07/22/14 at 5:00 PM, on 07/25/14 at 3:30 PM; and, on 07/31/14 at 6:25 PM, with Resident #32 revealed when he/she had to wait to "pee-pee", he/she "wet" his/her self. Resident #32 stated when that happened it made him/her feel "no good, like a baby". Resident #32 revealed he/she had to wait about forty (40) minutes at night for his/her call light to be answered, and at times became incontinent of urine. Resident #32 stated there were not enough staff at night at times. Further interview with Resident #32 revealed he/she had talked to "the people over the building" before; however, nothing had been done and he/she still had to wait for the call light to be answered and "wet" on himself/herself. 3. Review of Resident #33's medical record revealed the facility admitted the resident on 04/22/11, with diagnoses which included Parkinson's Disease, Difficulty Walking, Arthritis,	F 353		

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F 353	Continued From page 261 history of Urinary Tract Infections (UTI's) and Muscle Weakness. Review of the Quarterly MDS Assessment dated 05/15/14, revealed the facility assessed Resident #33 as having a BIMS score of fourteen (14), which indicated no cognitive impairment and the resident was interviewable. Continued review of the MDS revealed the facility assessed the resident to require extensive assistance of two (2) staff to assist with toileting, and to be occasionally incontinent of urine and to have a colostomy. Review of Resident #33's Comprehensive Care Plan, dated 05/19/14, revealed the resident was care planned for requiring assistance with ADLs and for the potential for complications related to his/her incontinence of bowel and bladder. Interview, on 07/03/14 at 2:25 PM, with Resident #33 revealed it took staff "a long time" for staff to answer his/her call light. The resident stated he/she had a "weak bladder" and when he/she had to go to the bathroom, he/she had to go right away. According to Resident #33, during the night it was worse, and he/she had been incontinent of urine waiting for staff to respond to the call light during the night. Resident #33 stated sometimes he/she "wet" on himself/herself while waiting on staff to respond to the call light. Resident #33 stated this made him/her feel "bad". Further interview with Resident #33 revealed "sometimes" he/she became "frustrated" when staff did not come "fast enough" to assist him/her. In an additional interview with Resident #33 on 07/29/14 at 6:30 PM, revealed there was "not enough staff for sure" at night. Resident #33 stated at night sometimes there was only one (1) staff person to help him/her to the bathroom, and he/she needed two (2) because his/her balance	F 353		

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F 353	Continued From page 262 was "real bad". Resident #33 reported feeling "frustrated" at times when staff didn't answer his/her call light fast enough to help him/her. Per interview, Resident #33 indicated staff had talked to him/her regarding his/her concerns with night shift; however, no one had followed up with him/her on his/her concerns. 4. Review of Resident #36's medical record revealed the facility admitted the resident on 11/02/11, with diagnoses which included History of Dehydration, Acute Renal Failure, Diabetes Mellitus and Rhabdomyolysis (a rare condition in which muscle cells break down and release a substance into the blood which could lead to kidney failure). Review of the Quarterly MDS Assessment, dated 06/16/14, revealed the facility assessed Resident #36 to have a BIMS score of fourteen (14) which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #36 to require extensive assistance of two (2) staff for transfer and one (1) staff assist with other ADLs except eating. Further review of the MDS Assessment revealed the facility assessed Resident #36 as being frequently incontinent of urine and always continent of bowels, and requiring a one (1) person assist toileting. Review of the Comprehensive Care Plan, dated 06/17/14, revealed Resident #36 was care planned for ADL self care deficit, and for the potential for complications related to his/her incontinence of bladder. Interview, on 07/24/14 at 2:10 PM, with Resident #36 revealed he/she took himself/herself to the	F 353		

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F 353	Continued From page 263 bathroom because he/she had to wait twenty (20) to thirty (30) minutes "sometimes" for his/her call light to be answered. However, Resident #36 stated he/she often had "accidents" in his/her pull up adult brief because his/her bladder was "so bad". Resident #36 stated staff was busy and couldn't get to him/her "right away" at times. Resident #36 revealed "sometimes" the facility was "really short of help at night time", and at times he/she waited twenty (20) to thirty (30) minutes for his/her call light to be answered. 5. Review of Resident #8's medical record revealed the facility assessed Resident #8 to have a BIMS score of fifteen (15) indicating the resident was cognitively intact and interviewable. Interview, on 07/25/14 at 11:20 AM, with Resident #8 revealed during the night shift there was "not enough staff" and "there were 'issues' due to this", such as, call lights not being answered timely. 6. Review of Resident #16's medical record revealed the facility assessed Resident #16 to have a BIMS score of fifteen (15) indicating the resident was cognitively intact and interviewable. Interview, on 07/24/14 at 1:30 PM, with Resident #16 revealed it had taken forty-five (45) minutes at times for his/her call light to be answered. Resident #16 stated there was "just not enough help" in the facility. 7. Review of Resident #17's medical record revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact and interviewable.	F 353		

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F 353	Continued From page 264 Interview on 07/24/14 at 1:49 PM, with Resident #17 revealed the resident had been interviewed about his/her care concerns, but no one had followed up with him/her after concerns were expressed on 07/03/14. According to Resident #17, sometimes he/she still had to wait for as long as thirty (30) minutes for the call light to be answered. Resident #17 stated night shift and weekends were the worst times, because there was not enough staff. Interview, on 07/31/14 at 10:14 AM, with the former Administrator, who was the Administrator from 05/15/14 through 07/11/14 when the current Administrator took over, revealed in the "morning meeting" held Monday through Friday staffing was discussed and the current day's call-ins were reviewed. However, the former Administrator stated the previous days call-ins and actual staffing were not looked at and discussed to identify patterns or trends. She stated the Human Resources (HR) Director had given her a "total number of hours" worked for each department. The former Administrator stated she had never been made aware of only one (1) SRNA working on a unit during the night shift. However, review of the Daily Staffing Sheets and Time Clock Punches for the 11:00 PM to 7:00 AM shift revealed on 06/06/14 five (5) staff was present in the facility after 3:00 AM, only two (2) of which were SRNAs (with a daily census of fifty-five (55) on the North Unit and forty-eight (48) on the South Unit); on 06/08/14, only three (3) SRNAs were present in the facility for the shift (with a daily census of fifty-five (55) on the North Unit and forty-nine (49) on the South Unit); and on 06/15/14, only three (3) SRNAs were present and working the shift (with a daily census of fifty-six	F 353		

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F 353	Continued From page 265 (56) on the North Unit and fifty-one (51) on the South Unit). If only three (3) SRNAs were working the shift it would leave one (1) unit with only one (1) SRNA. Continued interview revealed she didn't think last rounds in the morning for night shift for residents requiring two (2) person assist could be completed if there was only one (1) SRNA because the nurse would have to be on the medication cart. Per interview, the former Administrator stated having only one (1) SRNA on a unit on night shift "could negatively impact care". Interview, on 07/31/14 at 7:14 PM, with the SDC revealed she had come in at times and worked the floor as a nurse to pass medications and do treatments, or worked the floor as a nursing assistant when the staffing had been short and she couldn't find coverage. Interview, on 07/31/14 at 11:47 AM, with the current Administrator revealed he had taken over as Administrator on 07/11/14. He acknowledged being aware of staffing issues since taking over, and not having been told there was only one (1) SRNA at times on a unit during the night shift. The current Administrator stated there were vacancies and problems with "call-outs" which the SDC took care of during the day, and the Evening Shift Supervisor took care of in the evenings. He stated the SDC kept a report of "call-outs" which had been in place since he had became Administrator. Further interview revealed the SDC knew what the staffing was for the day, and would know the "call-outs" andfind replacement staff. He indicated if no replacement was found staff would be asked to stay over or a nurse might have to take on "another role", which meant the nurse would work the floor as an SRNA. The	F 353		

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F 353	Continued From page 266 current Administrator stated the facility made arrangements to cover staffing through the SDC or RN #5/Evening Shift Supervisor. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 that alleged removal of the IJ effective 07/29/14. Review of the AOC revealed the facility implemented the following: 1. The facility opened and investigated the five (5) reported allegations of neglect identified on the 06/30/14 through 07/03/14 Survey for Residents #5, #26, #27, #28, and #29. Initial Reports were completed with the five (5) day follow up reports pending completion of the investigations. The allegations were investigated by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant. 2. One hundred percent (100%) of the resident population received head to toe assessments by the DON, the ADON, MDS Coordinator, Wound Care Nurse, SDC, Evening Nurse Supervisor, Corporate Nurse Consultant and Charge Nurses on 07/23/14. 3. Residents with a BIMS of eight (8) or above were interviewed by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Supply Coordinator, Quality of Life Director or Chaplain which was completed on 07/25/14 for any abuse, neglect, or misappropriation concerns.	F 353		

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F 353	Continued From page 267 4. Families and responsible parties were interviewed for residents with a BIMS below eight (8) which was initiated on 07/25/14 and as of 07/28/14, thirty-seven (37) of fifty-six (56) had been completed, for any abuse, neglect, or misappropriation concerns. The facility would continue to attempt contacting families and responsible parties daily to identify any concerns until remaining Power of Attorney's (POA's) had been reached. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. 5. Staff was interviewed for any abuse, neglect, or misappropriation concerns by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Quality of Life Director or Chaplain on 07/25/14. Initial reports were made on the allegations relative to those interviews. 6. Initial Reports were made on 07/25/14 related to the alleged allegations relative to the interviews with residents, families, responsible parties, and staff. Thorough investigations were initiated on 07/25/14 by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant on those residents identified with appropriate follow up reporting on the allegations received. 7. Abuse, neglect and misappropriation audits, assessments, interviews and questionnaires were reviewed by the Special Projects Administrator, DON, Corporate Nurse Consultant or Chief Nurse Executive on 07/27-07/28/14 for any indications	F 353		

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F 353	Continued From page 268 of abuse, neglect or misappropriation concerns. 8. The Medical Director was notified of the Immediate Jeopardy on 07/25/14 by the DON and Special Projects Administrator. An Emergency Quality Assurance (QA) Meeting was held on 07/26/14 with the Corporate Director of Risk Management, Clinical Nurse Executive, Corporate Nurse Consultant, Medical Director, Special Projects Administrator, DON, HR Director, SSD and SDC related to the Immediate Jeopardy. 9. The DON, two (2) ADONs, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions, Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse were re-educated on 07/23/14 and the Administrator was re-educated on 07/28/14, upon his return, by the Corporate Nurse Consultant on the Abuse, Neglect and Misappropriation Policy and Procedure which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans. They could not return to work until the abuse, neglect, misappropriation education was provided and post test administered and a one hundred percent (100%) score was obtained on the post test. If a manager did not score a one hundred percent (100%) on post test, the manager was immediately re-educated and a post test was re-administered. 10. The facility's Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director,	F 353		

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F 353	Continued From page 269 Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse educated stakeholders related to the Abuse, Neglect, and Misappropriation Policy which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans starting on 07/23/14 and continued until 07/28/14. No staff would be allowed to work until this education was provided and the post test administered and a one hundred percent (100%) score obtained. Eighty-seven (87) of ninety-six (96) were completed by 07/28/14. 11. Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse provided education to stakeholders which was initiated on 07/26/14 to nursing staff related to incontinence care and Activities of Daily Living (ADL's) care per the Care Plan and answering call lights. Calls and certified letters had been sent notifying staff they must complete training before returning to work relative to incontinence care and Activities of Daily Living (ADL's) Care per resident individualized Care Plan and answering call lights in a timely manner. 12. Education regarding the Abuse, Neglect and Misappropriation Policy would be included in the orientation process for newly hired staff. No	F 353		

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F 353	Continued From page 270 newly hired person would be able to work until this education was provided and a post test administered and one hundred percent (100%) score obtained provided by staff development. 13. Staff assessment of knowledge test regarding abuse, neglect and misappropriation was being administered by the Administrator, DON, ADON's, MDS Coordinator, SDC, Dietary Director, Medical Records Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse to five (5) staff members on each shift and different staff members until the immediacy was removed. 14. Ten (10) staff questionnaires would be administered daily to ensure continued understanding of the Abuse, Neglect and Misappropriation Policy. Results of the questionnaires, tests, ten (10) resident skin assessments of residents with a BIMS less than eight (8) per day, ten (10) residents with a BIMS greater than eight (8) interviews would be reviewed daily until the immediacy was resolved by the Administrator, DON, Nurse Consultant or Chief Nurse Executive. Any concerns revealed on the above to include injuries of unknown source would be reported immediately to the Abuse Coordinator, Administrator, DON, Corporate Nurse Coordinator, Regional Vice President of Operations, Special Projects Administrator, or Chief Nurse Executive. 15. Results of the staff questionnaires, resident interviews and skin assessments would be	F 353		

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F 353	Continued From page 271 reviewed daily by the Administrator, DON, Nurse Consultant or Chief Nurse Executive with results reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of plan. Based on the evaluation the QA Committee would decide at what frequency the staff questionnaire would need to continue. Concerns identified would be corrected immediately and reported to the Administrator or DON to ensure an investigation of suspected abuse, neglect or misappropriation was investigated/completed and reporting guidelines were met along with any reporting of violation of resident rights. 16. Administrator, DON, ADONs, MDS Coordinator, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Director, Plant Operations Director, Quality of Life Director, Wound Care Nurse, Corporate Nurse Consultant, Regional Vice President or Clinical Nurse Executive would conduct call light audits through direct observation and monitoring tool daily twenty-four (24) hours a day seven (7) days a week on each shift to monitor compliance until the immediacy was removed. Then five (5) call lights daily on each shift (fifteen (15) total) ongoing and reported to QA Committee weekly during immediacy and monthly after immediacy was removed. Charge Nurses would provide direct observation of call light responsiveness and ensure all residents were getting needs met for plan of care each shift. Incontinence care observation would be completed for ten (10) residents daily until the immediacy was removed then ongoing for five (5) residents daily with	F 353		

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F 353	Continued From page 272 results being reported to the QA Committee weekly during immediacy and monthly after the immediacy was removed. 17. Human Resources (HR) Director performed an audit of staff files for any abuse, neglect or misappropriation concerns 7/26/14 through 7/27/14 and the items reviewed included coaching, counseling forms, suspension forms, termination forms, abuse registry checks, background checks and licensure to 07/03/14. Results of the audit was given to the Administrator, DON or Corporate Nurse Consultant on 07/27/14, to review for any abuse, neglect or misappropriation concerns that needed reported. None were identified. 18. Information on "Caring for the Caregiver" which addresses the signs of stress and burn out, showing the caregiver ways to cope and reduce stress and useful ways that friends could offer help to the caregiver were posted by the time clock on 07/27/14 by the Special Projects Administrator. 19. A nurse from the regional team or corporate office had been onsite since 07/21/14 and would remain in the facility daily until the Immediate Jeopardy was lifted. The nurses from the regional team home office were assisting with investigations, observing staff treatment of residents, performing chart audits and providing oversight and consultation. The Chief Nurse Executive would be in daily contact with the Corporate Nurse Consultant and would review allegations. 20. Grievances and Resident Questionnaires since 07/23/14 were reviewed by the	F 353		

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F 353	Continued From page 273 Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director or Regional Nurse Consultants 07/27/14 through 07/28/14 to determine if any items documented were a reportable event. All issues identified were reported and investigations initiated per the facility's policy and procedure. The Administrator, SSD, or the DON would review daily, the grievances and Incident/Accident Reports, until immediacy was lifted, starting 07/27/14 to determine if there were reportable allegations which had been identified, then daily Monday through Friday during the Morning Stand-Up Meeting. SSD or the DON would report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator would review any allegations of abuse, neglect or misappropriation for reporting to the Office of Inspector General, Adult Protective Services and Ombudsman and appropriate authorities as required by state law. 21. The Administrator, DON, SSD would review and discuss abuse, neglect and misappropriation allegations daily to ensure the resident was protected, the perpetrator was removed from resident care area, reports to the State Survey Agency, APS and Ombudsman were filed timely, and a thorough investigation was completed. The Abuse Coordinator (SSD) would maintain an abuse, neglect and misappropriation investigation log starting on 07/27/14 that would include documentation of the following: validate protection of residents; perpetrator was removed from resident care area; reports to the State Survey Agency and Adult Protective Services (APS) were filed timely; and a thorough investigation was completed. The Abuse Coordinator and one of the following:	F 353		

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F 353	Continued From page 274 Administrator, DON, Chief Nurse Executive or Regional Nurse Consultant would review the abuse, neglect and misappropriation log daily until removal of the Immediate Jeopardy, beginning on 07/27/14, to validate protection of the resident, that the perpetrator was removed from the resident care area, that reports to the State Survey Agency and APS and appropriate authorities required by state law, were filed timely, and a thorough investigation had been completed. 22. In the event of any new reports of alleged abuse, neglect, or misappropriation of property, after the Immediate Jeopardy was removed, the Signature Care Consultant or Chief Nursing Executive would validate the resident was protected, report was filed timely, the perpetrator was removed from resident care area and a thorough investigation was completed. 23. Beginning on 07/27/14, the care plan conferences for each resident would include any abuse, neglect or misappropriation concerns which the residents or families had. Resident safety would be validated and then the allegation would be reported to the Charge Nurse. The Abuse,Neglect and Misappropriation Policy would then be followed. 24. Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, Chief Nursing Officer, Signature Care Consultant, member of the regional staff team or Chief Operating Officer daily until removal of the immediacy beginning 07/21/14, then weekly for four (4) weeks, then monthly.	F 353		

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F 353	Continued From page 275 25. A Quality Assurance Meeting would be held weekly for four (4) weeks beginning 07/26/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee would determine at what frequency any ongoing audits would need to continue. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of the facilities investigations revealed the five (5) reported allegations involving Resident's #5, #27, #28, and #29 have been completed with a five (5) day follow up. A re-investigation was done related to allegations for Resident #26. Interview, on 07/31/14 at 7:08 PM, with the Corporate Nurse Consultant revealed the facility had investigated the allegations regarding Resident's #5, #26, #27, #28, and #29 and found them all to be substantiated. 2. Review of copies of resident head to toe assessments revealed all residents were assessed and the assessments were performed on 07/23/14 on North and South Hall, with a recorded census on 07/23/14 of fifty six (56) residents on North Hall and fifty-one (51) residents on South Hall. There was no concerns revealed during review of the skin assessments. Interview, on 07/31/14 at 5:26 PM, with the Wound Care Nurse revealed she was in charge of the skin assessments, and she and other nurses completed skin assessments on one hundred percent (100%) of the residents in the building.	F 353		

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F 353	Continued From page 276 3. Review of Resident Interviews revealed residents with a BIMS of eight (8) and above were interviewed, which included forty-six (46) residents, related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. 4. Review of family interviews for residents with a BIMS of less than eight (8) revealed thirty-seven (37) of fifty-six (56) of these interviews were completed as of 7/28/14 related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. Interview with the DON on 08/01/14 at 10:00 AM, revealed the interviewable residents were interviewed, as well as, the families of residents with a BIMS score of less than eight (8) and she reviewed the interviews for any concerns. 5. Review of the Stakeholder (Staff) Investigative Interviews revealed they were conducted in reference to abuse, neglect and misappropriation concerns 7/23/14 through 7/25/14 for all regular and part-time staff. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM;	F 353		

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F 353	Continued From page 277 RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all interviewed and asked if they were aware of any abuse, neglect, or misappropriation. 6. Review of the allegations relative to the interviews with residents, families, responsible parties, and staff concerns revealed they were investigated with initial reports completed. Interview with the Corporate Nurse Consultant on 07/31/14 at 7:08 PM revealed there was several reportable allegations from the interviews which she assisted with conducting, and the facility investigated with follow up actions and reporting. 7. Review of the Abuse, Neglect, and Misappropriation audits, assessments, interviews and questionnaires revealed they were reviewed by the DON, Corporate Nurse Consultant, Chief Nurse Executive or Special Projects Administrator on 07/27/14 and 07/28/14. Interview with the DON on 08/01/14 at 10:00 AM revealed they expanded on the abuse questions giving scenarios to the staff to have them choose which type of abuse was occurring in the scenarios. She stated she reviewed the abuse audits, assessments, interviews, and questionnaires. 8. Review of the Quality Assurance Signature Sheet and Minutes revealed an Emergency QA meeting was held on Saturday, 07/26/14, with the Medical Director, Special Projects Administrator, Director of Nursing Services, Director of Clinical Risk Management, Staff Development, Certified	F 353		

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F 353	Continued From page 278 Nurse Executive, Corporate Nurse Consultant, Human Resources Director, and Social Services Director to discuss current Immediate Jeopardy deficiencies and a Plan of Correction. Interview with the DON on 08/01/14 and the Corporate Nurse Consultant on 07/31/14 at 7:08 PM confirmed the QA Meeting was held on 07/26/14 with the Medical Director. Interview with the HR Director on 07/31/14 at 5:45 PM revealed during the emergency QA Meeting they discussed the Immediate Jeopardy deficiencies and the reason for the deficiencies as well as discussed the audits, interviews, questionnaires and interviewing that was being done related to the deficiencies. 9. Review of the sign in sheets dated 07/23/14 regarding training for the Administrative staff of the facility regarding the Abuse, Neglect and Misappropriation Policy revealed the Certified Nurse Executive educated the DON, ADON's, MDS Coordinator, SDC, Dietary Director, Business Office Manager, Social Services Director, Chaplain, Admissions Director, Medical Records, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director , Quality of Life Director and Wound Care Nurse received the training. Review of the sign in sheet on 07/28/14 for training on the Abuse, Neglect and Misappropriation Policy, revealed the Administrator of the facility was educated on skin assessments, interviews, the Abuse, Neglect, and Misappropriation Policy, and the Education session regarding the Plan of Correction.	F 353		

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F 353	Continued From page 279 Interview with the ADON/UM of the South Unit on 07/31/14 at 3:30 PM, ADON/UM of the North Unit on 07/31/14 at 4:45 PM, HR Director on 07/31/14 at 5:45 PM, the Dietary Director on 07/31/14 at 6:15 PM, and the DON on 08/01/14 at 10:00 AM, revealed they received training on abuse, neglect and misappropriation and had to take a post test in which they had to score a one hundred percent (100%). Review of the post test administered for Department Administrative Managers revealed a score of one hundred percent (100%) related to abuse, neglect, and misappropriation education. Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant, revealed the Department Administrative Managers scored a one hundred percent (100%) on the post test related to abuse, neglect and misappropriation education. 10. Review of the inservices revealed education was conducted with stakeholders related to abuse, neglect, and misappropriation 07/23/14 through 07/28/14 in which they had to score a one hundred percent (100%) on the post test or retake the test. Interview with the Staff Development Coordinator (SDC) on 07/31/14 at 5:15 PM, and the SSD on 07/31/14 at 6:30 PM revealed she and other administrative staff educated the stakeholders related to abuse, neglect and misappropriation and completed these inservices. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at	F 353		

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F 353	Continued From page 280 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated on the facility's Abuse, Neglect and Misappropriation Policy, which included training, prevention, identification, investigation, protection and reporting. Review of the sign in sheets from 07/23/14 through 07/28/14 revealed inservices were conducted with the facility staff regarding the Abuse and Neglect Policy. Review of the post-test revealed some staff had to be re-educated and staff eventually received a one hundred percent (100%) on the post tests. Documentation provided from the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13	F 353		

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F 353	Continued From page 281 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated related to abuse, neglect, and misappropriation in which they had to score a one hundred percent (100%) on the post test or retake the test. 11. Review of the sign in sheets on 7/26/14 and documentation of education provided revealed additional education was conducted with stakeholders regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner to the facility staff. Review of documentation provided by the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Further review revealed the stakeholders had to score a one hundred percent (100%) on the post test or retake the test. Further review revealed all but four (4) prn (as needed) staff had taken the test and scored a one hundred percent (100)%. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received inservice training regarding incontinence care, ADL care per	F 353		

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F 353	Continued From page 282 resident individualized plan of care, and answering call lights in a timely manner. 12. Review of the new orientation schedule revealed all new employees will complete education regarding the facility's abuse and neglect and successfully complete post test. Interview with the SDC on 07/31/14 at 5:15 PM confirmed the abuse and neglect education was a part of the new orientation schedule for new employees. 13. Review of the Stakeholder Assessment of Knowledge Tests regarding the Abuse, Neglect and Misappropriation Policy revealed the test was administered to five (5) stakeholders each shift and continued with different stakeholders. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received the Assessment of Knowledge Test regarding abuse, neglect and misappropriation. 14. Review of the questionnaires, skin assessments, and interviews revealed ten (10) stakeholder questionnaires, ten (10) skin	F 353		

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F 353	Continued From page 283 assessments for residents with a BIMS of less than eight (8), and ten (10) interviews with residents with a BIMS of eight (8) or greater than eight (8) were administered daily related to understanding of the abuse, neglect, and misappropriation policy. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. Interview with the DON on 08/01/10 at 10:00 AM revealed, the facility was still administering ten (10) questionnaires to stakeholders a day, performing ten (10) skin assessments a day for residents with a BIMS of less than eight (8), and conducting ten (10) interviews a day with residents who had a BIMS of eight (8) or greater related to abuse, neglect, and misappropriation. 15. Review of the QA Minutes dated 07/26/14 revealed the stakeholder questionnaires, resident skin assessments and resident interviews were to be reviewed daily and results and were to be reported to QA weekly. Interview with the DON on 08/01/14 at 10:00 AM revealed the stakeholder questionnaires, skin assessments and resident interviews were reviewed daily by her and taken to the QA Meeting weekly. 16. Review of the call light audits revealed monitoring was being done twenty-four hours (24) a day on each shift. Further review of the call light audits revealed five (5) call lights audits was being done daily on each shift (fifteen (15) total) which was ongoing. Review of the audits for Incontinence care revealed observation of incontinence care was completed for ten (10) residents daily. Review of the call light audits	F 353		

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F 353	Continued From page 284 revealed an improvement in call light response time as the auditing continued. Interview on 07/31/14, with LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; and LPN #13 at 6:05 PM verified, as charge nurses they were providing direct observation of call light responsiveness and ensuring the residents were getting needs met as per the care plan. Interview with the DON on 08/01/14 at 10:00 AM, revealed call light audits were still being done twenty-four (24) hours a day on each shift and observation of incontinence care was still being done for ten (10) residents daily and the results of the audits would be taken to the weekly QA Meeting. 17. Review of the audits revealed the Human Resources Director conducted an audit of the personnel charts for any history of abuse, neglect, or misappropriation concerns and no concerns were identified. Interview with the HR Director on 07/31/14 at 5:45 PM revealed she had performed an audit of the personnel files looking for any abuse charge, coaching/counseling/suspension/termination related to abuse, license verification, criminal background checks and abuse registry checks. 18. Observation on 07/31/14 at 11:00 AM revealed a sign was posted by the time clock to personnel to address Caring for the Caregiver - signs of stress and burn-out. Interview with SRNA #24, on 07/31/14 at 2:00 PM, revealed she was aware of the sign at the	F 353		

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F 353	Continued From page 285 timeclock related to stress and burn out. Interview with the DON on 08/01/14 at 10:00 AM revealed there was a sign posted by the timeclock for personnel related to what to do if feeling stress and burn out. 19. Observation revealed a nurse from the corporate office of the facility was present on the facility throughout the survey. Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant revealed a Corporate Nurse had been in the building since 07/21/14 on someone would remain at the facility until the immediacy was removed. 20. Review of the Grievances and Resident Questionnaires since 07/23/14 revealed they were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director and/or Regional Nurse Consultants by 07/28/14. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed he had been reviewing daily the grievances, incident reports and resident and staff questionnaires to identify any reportable allegations and the facility was reviewing them daily Monday through Friday in the morning stand up meeting. He stated the DON and SSD were to report any allegations of abuse to him and he was to review the investigations to ensure there was corrective action, appropriate follow up, and reporting. 21. Review of the Allegation Log, revealed the	F 353		

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F 353	Continued From page 286 following; validate protection of residents, perpetrator removed from resident care area, reports to the Inspector General and APS were filed timely, and a thorough investigation was completed. Interview with the SSD on 07/31/14 at 6:30 PM revealed she was the Abuse Coordinator and she reviewed allegations of abuse and grievances daily with the Administrator. She stated Accident and Incident reports, allegations of abuse/neglect/misappropriation and grievances were reviewed daily in the clinical meeting Monday through Friday with the DON and other Administrative Staff. She stated there was a new tool used for logging investigations which included the date of submission, resident name, description of allegation, perpetrator, date the five (5) day investigation was to be completed, and the date state agencies were notified of the findings. The SSD stated she was responsible for keeping the log up to date with new reportable allegations. 22. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation that in the event of any new reports of alleged abuse, neglect, or misappropriation the Signature Care Consultant or Chief Nursing Executive would be contacted prior to making the final five day investigation to the State Survey Agency to validate the resident was protected,report was filed timely, the perpetrator was removed from the patient area and a thorough investigation was completed. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed in the event of any allegation of abuse, neglect or misappropriation, corporate	F 353		

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F 353	Continued From page 287 was to review the investigation prior to sending the five (5) day final report to the State Survey Agency. 23. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation stating care plan conferences would include any abuse, neglect or misappropriation concerns that the families or residents may have. Interview with the DON on 08/01/14 at 10:00 AM, revealed all care plan conferences would include questioning residents and families about any concerns related to abuse, neglect or misappropriation. 24. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed Corporate Administrative oversight of the facility was to continue until the immediacy was removed, then would continue weekly for four (4) weeks and then monthly. 25. Interview on 08/01/14 at 11:46 AM with the Administrator confirmed there would be a weekly QA meeting to include Corporate oversight weekly for four (4) weeks, then monthly and the last meeting was 07/26/14. He stated during the meeting they would discuss the audits and recommendations for frequency of continued audits related to the deficiencies cited.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	**F371** **Immediate Corrective Action For Residents Found To Be Affected** ♦ No specific resident(s) identified. DSM immediately corrected all items noted within the form 2567 on July 01, 2014.	

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F 371	Continued From page 288 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility's policy, it was determined the facility failed to maintain sanitary conditions as evidenced by the soiled appearance of the kitchen, with food build up on the walls, splatters on the wall and the incomplete cleaning schedule for the month of June 2014. The findings include: Review of the facility's policy titled "Cleaning and Sanitizing Dietary Areas and Equipment", undated, revealed all kitchen areas and equipment should be maintained in a sanitary manner, and be free of build-up of food, grease or other soil. Observation during the initial kitchen tour, on 06/30/14 at 1:15 PM, revealed the kitchen had a general appearance of food build-up on the walls and food splatters on equipment. Further observation of the kitchen revealed two (2) trash can liner cases located on an open rack near the food preparation (prep) table with a soiled, greasy appearance. Observation also revealed three (3) electrical plugs on conduit extensions from the floor with dried food particles at the base and around the top of the electrical plug box. Continued observation revealed dried brown stains on the side of the dish lowrater, which was	F 371	**Identification of Other Residents With The Potential to be Affected** ♦ DSM performed a sanitation inspection on July 01, 2014 to assure no additional issues were identified – none were noted. ♦ A review of the facilities Infection Control Program's tracking and trending report was also completed by the DON on July 01, 2014 to identify any resident which may have been affected. There were no residents identified. **Measures Taken To Assure There Will Not be a Recurrence** ♦ DSM immediately corrected all items noted within the form 2567 on July 01, 2014. ♦ Cleaning schedules were revised by the DSM on July 03, 2014 to assure all items addressed on 2567 were listed as well as clarifying the schedule as to what tasks are due daily, weekly and monthly. ♦ ***Director of Special Projects inserviced DSM on July 29, 2014 relative to policies and procedures on sanitation, adjustment of cleaning schedules, timely completion of assignments as well as signing off on assignments.***	

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F 371	Continued From page 289 located next to the coffee machine on the resident tray line, and the dried brown stains had run down the side of the dish lowrater. Observation, on 07/01/14 at 10:55 AM, revealed the back of the ice cream freezer had dried stains which ran down the back of the freezer. Interview with the Dietary Manager, on 07/01/14 at 11:10 AM, revealed the cleaning list with the month and year on it was located on the dry storage room door. She stated the kitchen staff was assigned specific areas and equipment to clean, and she checked the cleaning on a weekly basis. Review of the cleaning list titled "Cleaning Schedule", dated June 2014, revealed staff names were located beside each cleaning task; however, there were no dates to indicate when the task was to be completed, or when it had been completed by the staff assigned to it. Continued review revealed the "Cleaning Schedule" did not indicate if the cleaning task was to be completed daily or weekly. Further review revealed check marks were located beside the staff person assigned to a task, indicating it had been completed; however, some staff had not made check marks to indicate their task had been completed. Interview with Dietary Aide #1, on 07/03/14 at 10:55 AM, revealed the cleaning schedule located on the dry stock room door was for cleaning tasks to be completed daily and monthly. He stated staff were to use a cleaning cloth that was kept in a sanitizer solution for cleaning, and the sanitizer should be changed often. Dietary Aide #1 revealed each staff member was assigned to	F 371	♦ DSM inserviced all dietary staff on ~~July 03~~ ***July 29*** to September 12, 2014 relative to maintaining cleanliness, cleaning assignments completed timely as well as reviewing the revised schedules as well as reviewing revisions that have taken place over that time period. ♦ Daily direct observations/monitoring for cleanliness as well as review of the schedules for completion will be performed by the DSM, Assistant DSM (ADSM), Cook or Dietitian beginning September12, 2014. ♦ ***Administrator or designee will perform weekly sanitation reviews beginning September 26, 2014. These inspections will continue until directed otherwise by the QA Committee.*** **Monitoring Changes To Assure Continuing Compliance** ♦ Daily direct observations/monitoring for cleanliness as well as review of the schedules for completion will be performed by the DSM, Assistant DSM (ADSM), Cook or Dietitian beginning September12, 2014. ♦ Results of Daily direct observations/monitoring for cleanliness and cleaning schedules was added to the Monthly Dietary Quality Assurance Report beginning September 2014 report. QA Committee shall determine cessation or continuation based on compliance achieved.	

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F 371	Continued From page 290 specific areas to clean, and when the area had been cleaned staff was to make a check mark on the list indicating it had been completed. He stated the Dietary Manager checked often to see if the cleaning had been done, and would "write up" staff if the cleaning had not been done. Interview with Dietary Aide #2, on 07/03/14 at 11:00 AM, revealed the cleaning schedule located on the dry stock room door was a daily and weekly cleaning schedule. Dietary Aide #2 stated the Dietary Manager instructed staff on how to clean. She stated the staff was to use sanitizer to clean surfaces. She further revealed the cleaning schedule was rotated and she might be assigned to clean the walls, then might be assigned to clean the milk cooler later. According to Dietary Aide #2, staff were to check off on the list when their assigned cleaning was completed, and they had a full month to complete all the cleaning. Interview with Cook #1, on 07/03/14 at 11:05 AM, revealed the cleaning schedule was located on the dry stock room door. Cook #1 stated the Dietary Manager instructed him on how to clean, using a rag in sanitizer and changing the sanitizer often. He stated the cleaning list was for weekly cleaning, and the assigned staff was to check off their assigned cleaning as completed. Interview with Cook #2/Supervisor, on 07/03/14 at 11:10 AM, revealed the cleaning list was located on the dry stock room door. He stated the cleaning schedule was for weekly cleaning, and he assisted the Dietary Manager to check on the weekly performed by staff. He indicated the Dietary Manager trained staff on how to clean, and he had prior training and experience himself on cleaning. Cook #2/Supervisor stated he used	F 371	**Date of Completion:**	**09/27/2014**

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F 371	Continued From page 291 a cleaning cloth placed in sanitizer and cleaned the surfaces in the kitchen. He revealed the sanitizer was changed two (2) to three (3) times per day. Cook #2/Supervisor stated he usually was responsible for weekly cleaning of the ovens, steam table and steamer. Interview with Dietary Aide #3, on 07/03/14 at 11:12 AM, revealed the cleaning schedule was located on the store room door, and was divided into four (4) weeks. He stated the Dietary Manager instructed staff on cleaning, and stated he used bleach in the dishroom and sanitizer on a rag to clean in the kitchen daily. Dietary Aide #3 revealed the assigned areas for staff to clean were changed monthly. He stated he made a check mark when the cleaning was completed. Interview with the Dietary Manager, on 07/03/14 at 11:20 AM, revealed the current cleaning schedule form was made from the corporate form which did not list all the equipment or areas of the facility's kitchen. She stated Cook #2/Supervisor assisted her in making weekly observations of the cleaning performed by staff and assisted staff as needed. She revealed she made weekly observations of the cleaning schedule list to ensure the cleaning assigned had been completed and checked off. The Dietary Manager stated she needed to change the cleaning schedule to include a separate daily cleaning list to ensure the kitchen areas were cleaned daily after meal production.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	**F 441** **Immediate corrective action for resident found to be affected** ♦ Resident # 6 discharged from the facility on July 28, 2014. ***However, skin assessment***	

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F 441	Continued From page 292 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was	F 441	*was performed on July 23, 2014 by Licensed Nurse as well as peri-care observation was performed by the ESNS on July 25, 2014 with no issues identified.* **Identification of residents that have the potential to be affected:** ♦ A *review of the facilities Infection Control Program's tracking and trending report was also completed by the DON* on August 01, 2014 to identify any resident which may have been affected. There were no residents identified. **Measures taken to assure there will not be a recurrence:** ♦ In-services were completed to all nursing staff on August 25 to September 12, 2014 by the DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses related to infection control policy and procedure for hand washing, glove use and Foley catheter care. ♦ Competencies were completed by DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses for all staff related to hand washing. These were performed on August 25 to September 12, 2014. Any staff not receiving a competency check by September 12, 2014 will not be allowed to work a shift until being checked off. ♦ Competencies will be completed by DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses for all SRNAs for Foley	

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F 441	Continued From page 293 determined the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for one (1) of thirty-seven (37) sampled residents (Resident #6). Observation revealed staff did not wash their hands prior to exiting the isolation room for Resident #6, who was in contact isolation for Clostridium Difficile (C-diff) of the stool (a bacterium that could cause symptoms ranging from diarrhea to life threatening inflammation of the colon), and Escherichia Coli (E-coli) ESBL (Extended Spectrum Beta Lactamase) and Enterococcus Faecium VRE (Vancomycin Resistant Enterococcus) of the urinary tract. ESBL and VRE are multi-drug resistant organisms and were the bacterial source of the resident's Urinary Tract Infection (UTI). Also, staff failed to remove their soiled gloves and wash their hands after providing incontinence care for Resident #6, and prior to touching objects in the resident's room. In addition, staff performed "Foley" catheter (indwelling urinary catheter) care by cleaning the catheter tubing upwards towards the catheter insertion site. The findings include: Review of the facility's "At-A-Glance-Hand Washing and Use of Gloves" policy, effective December 2010, revealed handwashing was the single most important measure of preventing the spread of infections. Continued review revealed handwashing was to be performed before and after resident care and after handling contaminated articles.	F 441	catheter care. These were performed on August 25, 2014 to September 12, 2014. Any SRNA not receiving a competency check by September 12, 2014 will not be allowed to work a shift until being checked off. ♦ Beginning ~~August 02~~ ***September 26***, 2014, five observations daily ***(Given low volume of isolation residents and in order to reduce inconvenience to them, they will be included randomly with at least one observation for infection control practices per week including entering and exiting)*** are being conducted during rounds on each shift by the DON, ADON, MDSN, WCN, SDC, ESNS, SCC, ***WNS*** or licensed nurses for hand washing and Foley catheter care. **Monitoring to assure continuing compliance:** ♦ Beginning August 06, 2014, the Director of Nursing (DON) shall present all observations and competency findings to the Quality Assurance (QA) committee weekly x 4 and then monthly for any further recommendations or resolutions. **Date of Completion:** 09/27/2014	

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F 441	Continued From page 294 Review of the facility's "Isolation-Categories of Transmission Based Precautions" policy, revised August 2012, revealed contact precautions were to be used for residents known or suspected to be infected with microorganisms which could be transmitted by direct contact with the resident, or indirect contact with environmental surfaces or resident care items in the resident's environment. Continued review revealed while caring for a resident staff were to: change their gloves after having contact with infective material, such as feces; remove the gloves before leaving the room, and perform hand hygiene; not touch potentially contaminated environmental surfaces or items in the resident's room after removal of gloves and hand washing. Review of the facility's policy titled "Clostridium Difficile", revised August 2013, revealed when caring for residents with diarrhea or fecal incontinence caused by C-diff, staff were to maintain vigilant hand hygiene. Further review revealed staff were to use gloves when caring for the resident with a C-diff infection, and wash their hands with soap and water upon exiting the room. Review of the facility's policy titled "Foley Catheter Care", effective December 2010, revealed the purpose of catheter care was to prevent possible urinary tract infections from bacteria spreading from the perineal area and external catheter into the bladder. Further review revealed perineal care consisted of washing the perineal area and catheter with clean, warm, soapy water followed by rinsing the areas. In addition, review revealed the policy did not specify under the "procedure" section in which direction the "Foley" catheter was to be cleaned.	F 441		

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F 441	Continued From page 295 Review of Resident #6's medical record revealed diagnoses which included Cerebrovascular Accident (Stroke) with Left Hemiparesis (weakness on one side of the body), C-diff, Decubitus Ulcers, and E-coli ESBL and Enterococcus Faecium VRE UTI. Review of the laboratory (lab) information and reports revealed a stool for C-diff was collected 06/10/14 and reported on 06/11/14 as positive for infection. Review of the Physician's Orders revealed on 06/11/14 Flagyl (an antibiotic medication) 500 milligrams (mgs) three (3) times a day for ten (10) days was ordered. Continued review of the Physician's Orders revealed on 06/29/14 orders for Flagyl 500 mgs three (3) times a day for ten (10) days; and, on 06/30/14 for the Flagyl to be extended four (4) days, for a total of fourteen (14) days, related to the C-diff infection. Additionally, continued review of the lab information and reports revealed a urine was collected on 06/27/14 and reported on 06/29/14 as E-coli ESBL and Enterococcus Faecium VRE. Further review of the Physician's Orders revealed on 06/30/14, an order for Macrobid (antibiotic medication) 100 mgs twice a day for ten (10) days for a UTI. 1. Observation of Resident #6's room, on 07/01/14 at 4:10 PM, revealed a sign outside the door which stated, "See nurse before entering, contact isolation", and a plastic bin with drawers beside the door which contained Personal Protective Equipment (PPE), including gowns, gloves and shoe covers for staff. Observation from 4:10 PM until 5:05 PM revealed Licensed Practical Nurse (LPN) #6 and LPN #7 donned the PPE, entered Resident #6's room and performed "Foley" catheter care and incontinence care related to the resident having had a large diarrhea	F 441		

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F 441	Continued From page 296 stool. Continued observation revealed the two (2) nurses then performed a skin assessment, measured wounds and performed dressing changes to pressure ulcers on the resident's right buttock and left heel using infection control technique. Observation revealed LPN #7 placed the soiled linens in a clear bag and then a yellow bag, removed her PPE and placed it in a red biohazard hamper in the room, opened the door and left the room without washing her hands. LPN #7 was observed to go across the hall and into the dirty utility room, using a keypad punch to open the door. Further observation revealed SRNA #16 removed her PPE and exited the open door without washing her hands, and proceeded into the dirty utility room. In addition, LPN #6 removed her PPE, and without washing her hands exited the open door of the resident's room, and went down the hall and through the nurse's station entrance. Interview with SRNA#16, on 07/01/14 at 5:05 PM, revealed she had been instructed to remove her PPE, and go straight to the soiled utility room and wash her hands in the soiled utility room after exiting an isolation room. She stated this would keep her from taking off the shoe covers and then going back across the resident's room to the bathroom to wash her hands, which could cause her to re-contaminate herself. She stated she had not had a recent inservice related to isolation procedures or infection control. Interview with LPN #6, on 07/01/14 at 5:07 PM, revealed she had left the isolation room and gone to the sink at the nurse's station to wash her hands and did not touch anything but the sink. She stated she would not want to remove her PPE and then walk back across the isolation	F 441		

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F 441	Continued From page 297 room to wash her hands because she could cross contaminate herself. Interview with LPN #7, on 07/01/14 at 5:08 PM, revealed she did not wash her hands before exiting the isolation room because this would cause cross contamination if she walked back across the resident's room to the bathroom to wash her hands. She stated she could have contaminated the resident's door by opening the door, and also the keypad and door to the soiled utility room if there were germs on her hands after removing her gloves. She stated there had been no recent inservice related to contact precautions or PPE. Interview with the Infection Control Nurse, on 07/02/14 at 10:30 AM, revealed staff should wash their hands after removing the PPE and prior to leaving the contact isolation room. She further stated staff should wash their hands again when the soiled linens were put away after exiting the contact isolation room. 2. Continued observation of Resident #6, on 07/02/14 at 1:50 PM, revealed the sign stating, "See nurse before entering, contact isolation", and the plastic bin with PPE, remained outside the resident's room door. Observation revealed SRNAs #16 and #17 donned the PPE and entered Resident #6's room to provide incontinence care and weigh the resident. Observation of "Foley" catheter care revealed SRNA #17 cleansed bowel movement from the resident's perineal area, changed the wet wipe but not her gloves, and cleansed the "Foley" catheter tubing, which was covered with stool, upwards towards the vaginal area. Observation revealed SRNA #16 then cleaned the resident's	F 441		

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F 441	Continued From page 298 buttocks and applied protective ointment, holding the tube with her soiled gloves. Continued observation revealed SRNA #17 cleaned stool from Resident #6's buttocks, and also handled the protective ointment tube with her soiled gloves while applying ointment to the resident's buttocks. SRNA #17 placed the protective ointment in the resident's bedside drawer. Observation revealed SRNA #16 removed one (1) pair of gloves and stated she had "double gloved", and proceeded to place a lift sling under Resident #6. SRNA #16 was further observed to move the mechanical lift towards the resident and handled the lift controls to maneuver the lift down and then up again after hooking the lift pad onto it. The SRNAs were observed to obtain Resident #6's weight with the mechanical lift, unhook the lift pad, and remove the lift pad from under the resident. Observation revealed SRNA #16, with the same gloves, handed Resident #6 a lanyard (a rope or cord, typically worn around the neck, shoulder, or wrist) and placed it around the resident's neck, and handed the resident his/her purse and glasses. Continued observation revealed SRNA #17 removed her PPE, opened the door and exited the room without washing her hands, taking the yellow bag of soiled linens out the door and down the hall. SRNA #16 was observed to stay in the room while housekeeping cleaned the mechanical lift, then remove her PPE and exit the room without washing her hands. Interview with SRNA #16, on 07/02/14 at 2:30 PM, revealed she could "double glove" and take off the first pair after incontinence care and handle the mechanical lift because housekeeping cleaned the lift after use due to the resident being in contact isolation. However, she stated she should have washed her hands prior to handing	F 441		

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F 441	Continued From page 299 the resident his/her personal items, such as the lanyard, glasses and purse. She stated she exited the room without washing her hands because after she removed her PPE she did not want to go back across the resident's room and contaminate herself by using the resident's bathroom sink to wash her hands. Interview with SRNA#17, on 07/02/14 at 2:45 PM, revealed she knew she was to clean the "Foley" catheter from the vaginal area down towards the urinary drainage bag; however, she had inadvertently cleaned the wrong way in an attempt to get the bowel movement cleaned up. She stated she had contaminated the protective ointment with her soiled gloves and placed it in the resident's top drawer which could contaminate other items in the drawer. She stated she did not know how she was to use the ointment without contaminating the tube. SRNA #17 stated she had exited the room without washing her hands after removing the PPE and washed her hands down the hallway at the nurse's station as she did not want to walk back across the resident's room without her PPE. Record review revealed an inservice was given on 06/06/14 related to Contact Isolation, C-diff, and Handwashing. Review of the staff signatures for the inservice revealed SRNA #17 and LPN #6 had attended; however, there were no signatures for SRNA #16 and LPN #7 indicating they had attended the inservice. Continued interview with the Infection Control Nurse, on 07/03/14 at 4:30 PM, revealed staff were to wash their hands prior to exiting isolation rooms, and again after exiting the room if handling soiled items, such as biohazard bags.	F 441		

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F 441	Continued From page 300 She stated staff should wash their hands and use new gloves before performing "Foley" catheter care, and were to clean the catheter tubing from the vaginal area down towards the drainage bag. The Infection Control Nurse further stated there had been no recent inservice related to catheter care; however, staff received inservices related to this on orientation and yearly. She stated she randomly observed and audited catheter care and incontinence care, and if she saw a problem she stopped the staff right then and corrected them. The Infection Control Nurse revealed she never taught staff to "double glove", and she had inserviced staff related to glove usage by telling them to change gloves and wash their hands as many times as necessary when providing care. She stated the protective ointment would be contaminated if handled with soiled gloves. She further stated staff should have removed their soiled gloves and washed their hands before handling items in the room, such as the mechanical lift and Resident #6's personal items. Continued interview revealed she did not teach staff they could not walk back across the isolation room to the bathroom to wash their hands after removing the PPE. She stated she recently did an inservice related to contact isolation, C-diff, and blood borne pathogens. In addition, she stated all new hires receive an infection control inservice, and this was also done yearly.	F 441		
F 490 SS=K	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.	F 490	**F 490** **Immediate corrective action for residents found to be affected:** ♦ ~~No residents were identified to be affected Please refer to Ftags 166, 224, 225 and 226 for residents identified and~~	

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F 490	Continued From page 301 This REQUIREMENT is not met as evidenced by: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K". Based on observation, interview, and review of the facility's "Disaster Preparedness" Manual, Fire Emergency Guidelines and Evacuation Plan, during the 07/03/14 survey, it was determined the facility's Administrator failed to have an effective system in place to ensure the residents' environment remained as free from accident hazards as possible, and failed to ensure the facility's evacuation route was updated and facility staff was trained and knowledgeable regarding which fire exits were appropriate for evacuation during the construction, which affected three (3) exits identified by the facility as emergency exits. On 06/24/14 the facility began construction by removing the concrete pavement outside the	F 490	~~cor3ective actions taken.~~ ***Resident #8, 16, 17, 32, 33, and 36 have all had grievances completed July 23 to July 25, 2014 by SSD, Administrator, DON, MRM, QoLA, ESD, DOA, MDSN, HRD/AIT and QoLD to include follow-up and resolution reported to all appropriate state agencies.*** ♦ ***On July 23 to July 25, 2014 residents #5, 26, 27, 28, and 29 had investigations opened related to allegations of neglect and initial reports were completed as well as 5 day follow-up reports to all appropriate state agencies. SSD met with each of the residents to assess for any issues or complaints.*** **Identification of other residents that have the potential to be affected:** ♦ All residents residing on the Northwest and Southwest halls have the potential to be affected. There is no construction at this time, thus no other residents are affected. ♦ ~~***Please refer to Ftags 166, 224, 225, 226 and 353 for specific residents and corrective actions taken. 100% of the resident population received head to toe assessments on July 23 to July 28, 2014 by the DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses.***~~ ♦ ***All residents with BIMs of 8 or above were interviewed on July 23 to July 25, 2014 by SSD, HRD/AIT, QoLD, QoLA, MRM, Chaplain, BOM, DOA, ADON, SDC, SCC***	

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F 490	Continued From page 302 Northwest hallway exit and and the Dining room exit and on 06/27/14 the the Southwest exit door had pavement removed, affecting the safe path to a public way for these three (3) exits. Although these three (3) exits were designated as fire evacuation exits, observation revealed the three (3) exit doors led to drop offs, large gravel, rebar and an uneven rocky and dirt surface. The facility's emergency exit routes included these exits at the end of the Northwest and Southwest hallways. There was a total of sixty (60) of the facility's one hundred and twenty-four (124) residents residing on these hallways with the potential to be affected in case of an emergency evacuation. Also, the map posted in the Dining room revealed arrows leading to the outside, indicating the door located in the dining room was an exit route, although there was construction outside that exit. (Refer to F-323, F-518 and F-520) The facility's Administrator's failure to have an effective system in place to ensure the residents' environment remained as free from accident hazards as possible, and each resident received adequate supervision to prevent accidents was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/30/14 and determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at a Scope and Severity of a "E", while the facility develops and	F 490	***and ESNS with any concerns voiced taken through the grievance process for follow-up and resolution.*** ◆ ***All residents with a BIMS below 8, Responsible Parties, POA or Guardian were interviewed on July 23 to August 04, 2014 by SSD, HRD/AIT, DOA, MRM, Chaplain, BOM, ABOM, ESD, DSM, SCC, ADON, QoLA and QoLD with any concerns taken through the grievance process for follow-up and resolution. Anyone unable to contact were sent certified letters on July 29, 2014.*** ◆ ***Staff was interviewed on July 23 to August 10, 2014 for any abuse, neglect or any misappropriation or concerns by the DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, SCC, BOM, DOA, RSM, QoLD, WCN, WNS, Chaplain and SSD.*** ◆ ***Initial reports were completed as well as 5 day follow-up for any concerns identified. Thorough investigations were completed and forwarded on to the state agencies as necessary.*** **Measures taken to assure there will not be a recurrence:** ◆ SCC in serviced Administrator and entire safety & QA committees consisting of DON, ADON, MDSN, SDC, WCN, DOA, BOM, RSM, MRM, DSM, ESD, SDC, POD and HRD/AIT, SSD, QoLD, QoL QoLA and Chaplain. Education was	

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F 490	Continued From page 303 implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure compliance with systemic changes. Based on interview, record review, and review of the facility's investigation reports and policies, during the 08/01/14 survey, it was determined the facility's Administrator failed to ensure their abuse and neglect policies were implemented by staff as evidenced by failing to ensure all allegations of abuse, including neglect were investigated thoroughly, and failing to ensure residents were protected from further neglect. On 07/03/14, Resident #26 rang the call bell for incontinence care assistance at approximately 5:30 AM; however was not assisted until approximately 7:45 AM, (two hours and fifteen minutes later). Interview with the day shift State Registered Nursing Assistant (SRNA), who assisted Resident #26 at 7:45 AM, revealed the resident was soaked with urine and covered in bowel movement. Staff interviews further revealed other residents were also left soaked in urine or soiled with bowel movement the morning of 07/03/14, after day shift reported to work at 7:00 AM. These residents included #5, #27, #28, and #29. Although Administration became aware of the allegations related to Resident #5, #26, #27, #28, and #29, on 07/03/14, and completed an investigation, the investigation was not thorough and was not reviewed by the Director of Nursing (DON) or the Administrator. In addition, the investigation revealed a conflict between the two (2) SRNA's who worked the South Unit on the night shift noting they did not work together as a team for residents requiring two (2) person assist	F 490	provided from June 30 to July 01, 2014 and covered construction planning and continued safety of the residents, additionally the construction plan and assignments, that delineated which staff was responsible for AOC were dispersed to all departments. ♦ Construction plan initiated on June 30, 2014 included new rounds, amended exit diagrams and placement of signage in appropriate areas that included all public and employee entrances indicating which doors closed related to construction. New signs related to "DO NOT USE" were placed on the affected doors. ♦ In-services performed for all staff from June 30 to July 01, 2014 by SCC, Administrator, DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, MRM, BOM, DOA, RSM, QoLD, QoLA, WCN, Chaplain and SSD for all staff. Education consisted of the new evacuation plan and continued safety of the residents. ♦ All residents of BIMS 8 or greater were informed of the construction and alternate evacuation routes and signs from June 30 to July 01, 2014 by the SSD and QoLD. ♦ Responsible parties of resident with BIMS less than 8 were notified of the construction and temporary evacuation routes from June 30 to July 01, 2014 by the Chaplain and DOA.	

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F 490	Continued From page 304 with ADL's. However, Administration failed to address this conflict between the two (2) SRNA's to prevent further resident neglect. (Refer to F-224, F-225, F-226) The facility's Administrator's failure to have an effective system in place to ensure residents were protected from neglect was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/25/14 and was determined to exist on 07/03/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at 42 CFR 483.75 Administration (F-490) at a Scope and Severity of a "E" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors to ensure compliance with systemic changes. The findings include: Reference F-323, F-518 and F-520 1. Review of the facility's, "Disaster Preparedness" Manual, dated January 2005, revealed the fire safety procedure plan which noted what staff were to do when preparing for an evacuation. Review revealed when the fire alarm sounded staff were to first check the primary exit route, and if it was clear and safe, use that exit if evacuation of the facility was ordered. Review of the facility's Fire Emergency Guidelines, undated, for the North and South Units revealed staff were to check the primary	F 490	♦ Signs were placed on main entrance and employee doors that construction is in progress on June 30, 2014 by the HRD/AIT and POD. ♦ All new temporary diagrams were created for southwest hall, northwest hall, dining room, dietary services and laundry area by the POD and posted on all temporary alternate evacuation routes on June 30, 2014. ♦ Medical director was notified on June 30, 2014 by the DON and is in agreement with steps taken. ♦ All staff has been educated on environmental hazard identification by the SCC, Administrator, DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, MRM, BOM, DOA, RSM, QoLD, QoLA, WCN, Chaplain and SSD. This education was performed on August 25, 2014 to September 12, 2014. Any staff member not educated by September 12, 2014 will not be allowed to work a shift until being educated. ♦ Beginning August 02, 2014 the POD or POD Assistant (PODA) will conduct environmental hazards rounds weekly x4 weeks to identify any potential hazards and forward results to the Administrator. After the first 4 weeks, these will be conducted monthly and forwarded to the Administrator.	

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F 490	Continued From page 305 exit route, and if it was blocked they were to use the secondary route. Review of the maps on 06/30/14, posted across from the nurse's station on both units and in the Dining room revealed the Northwest hallway exit door, Southwest hallway exit door, and Dining room exit door were marked with arrows indicating they were exit routes to be taken. Observations on 06/30/14 from 5:15 PM to 5:24 PM revealed outside the dining room exit door a concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar (steel bar used in construction to reinforce concrete); outside the Northwest hallway exit door a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar; and, outside the exit door at the end of the Southwest hallway a ramp which led to a four and a half (4.5) inch drop off with gravel. Further observation on 06/30/14 from 5:15 PM to 5:24 PM revealed there were no signs posted at the Southwest hallway exit door, Northwest hallway exit door, and dining room exit door to alert staff, residents, and visitors these exits were not accessible due to construction. Also, there was no posting of new evacuation routes in case of fire or other emergencies due to the exits not being accessible, despite the facility's knowledge there was not a safe pathway to a public way due to construction for those three (3) exits. The facility's Administration provided no documented evidence it had evaluated and/or revised the evacuation plan related to the Northwest hallway fire exit, the Southwest hallway fire exit or the dining room fire exit having no safe path to a public way. In addition, there was no documented evidence staff was trained and	F 490	♦ ~~*Please refer to Ftags 166, 224, 225, 226 and 353 which shall be incorporated herein.*~~ *Education was completed by the SCC on July 23 to July 30, 2014 related to current corporate policies, which was previously approved by CMS and states on page 1, "all allegations of abuse will be investigated" and government regulations on abuse, neglect and misappropriation to DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM and Administrator. Training included investigations, prevention, identification, protection, and reporting as well as providing care per residents individualized care plans.* ♦ *100 % of all stakeholder were educated beginning on July 23, 2014 to July 30, 2014 by DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC related to current corporate policies (which was approved by CMS and states on page 1, "all allegations of abuse will be investigated"), and government regulations on abuse, neglect, misappropriation incontinence care, and activity of daily living and the answering of call lights. Re-educated all staff on August 25 to September 12, 2014.*	

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F 490	Continued From page 306 knowledgeable regarding which fire exits were appropriate for evacuation during construction. Interviews with staff revealed they would have used the Northwest hallway, Southwest hallway, and dining room exits to the outside if an emergency arose which required residents to be evacuated from the facility. Interviews revealed they did not think those exits had been affected and they had not been told by the facility to not use those exits. Interview, on 06/30/14 at 5:05 PM, with the Director of Nursing (DON), revealed she was told on the morning of 06/17/14, during the "Stand Up Meeting" construction was to start on 06/18/14 and this included repairing concrete and those present were told to stay clear of the exit doors to the Northwest and Southwest hallway exits as the sidewalks were being replaced outside those doors. She revealed the Staff Development Nurse (SDN) inserviced staff related to the construction; but, she was not sure if all facility staff had been inserviced by the SDN. The DON reported she had not been inserviced as to an alternate evacuation route for an emergency evacuation. Per interview the DON stated knowledge of an alternate evacuation plan and inservicing staff on it would be important to have as staff would not be able to get residents' wheelchairs out the exits where the construction was taking place. Interview with the SDN on 06/30/14 at 5:30 PM, revealed she was told by the DON to inform staff of which doors would be inaccessible due to construction; however, she was not told who to inservice and was not told exactly what the new evacuation routes would be. According to the	F 490	♦ ***Education of abuse, neglect, misappropriation policy will be included in the orientation packet for newly hired employees beginning September 12, 2014. Post tests were completed for all stakeholders to assure learning and understanding of policy and procedures.*** ♦ ***Beginning August 02, 2014, Ten staff inservice questionnaires are being administered daily DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC to ensure continued understanding of abuse and neglect policy and procedure. Results of the questionnaires and tests are to be reviewed by the Administrator, HRD/AIT, SSD or DON. Any Stakeholder unable to satisfy this requirement will be re-educated until satisfactory completion or removed from the schedule if unable to demonstrate understanding upon re-education. This will continue until instructed otherwise by the QA Committee.*** ♦ ***Investigation relative SRNA conflict was initiated on July 22, 2014 by HRD/AIT, SCC, DON or ADON interviewing stakeholders working July 2-3, 2014 to identify the conflict that had been reported to OIG. Investigation was completed on July 25, 2014 with SRNA #19 being terminated as a result of the investigation.***	

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F 490	Continued From page 307 SDN, therefore she did an informal verbal inservice at the last "Town Hall Meeting" which was held on payday Friday on 06/20/14 with staff who were picking up their paychecks. Review of the facility's, "Town Hall Meeting and Inservice Agenda" dated 06/20/14, revealed there was a list with bullets which included a bullet stating, "construction on drive". However, continued review revealed no written information referencing the information provided. Further review revealed there were twenty-eight (28) staff signatures listed for the inservice out of the one hundred and fifty (150) employees in the facility. Interview, on 06/30/14 at 7:00 PM, with the Administrator revealed she came to work at the facility on 05/15/14, and was told by the previous Administrator that day there would be construction taking place and this included replacing damaged pavement on the west or back side of the building. She stated she learned on 06/17/14 construction would be starting on 06/18/14; however, the construction was delayed and did not start until 06/24/14. The Administrator stated during the "morning meetings" she discussed the construction every few days. According to the Administrator, she talked about how the construction would consist of tearing up the concrete and re-pouring it at the back of the building. Per interview she stated however, they had not discussed the safety aspects related to the construction. Continued interview revealed she knew the SDN had inserviced staff at the last "Town Hall Meeting" which occurred on 06/20/14; but the SDN had not been told to specifically inservice all staff, and was not appraised of any new evacuation plan. The Administrator stated the facility's evacuation	F 490	♦ ***Beginning August 02, 2014, five residents with BIMS greater than 8 will be interviewed daily by DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC and reviewed by the Administrator, HRD/AIT, SSD, or DON. Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.*** ♦ ***Beginning August 02, 2014, five call light observations will be completed on each shift by the DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC. Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.*** ♦ ***Beginning August 02, 2014, incontinency care observations will be completed for five residents daily licensed nurse and results will be reviewed by the Administrator, DON, ADON, ESNS, WNS or***	

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F 490	Continued From page 308 plan stated if an exit could not be used for some reason, staff should use another exit. She stated however, if staff was unaware they could not use certain fire exit doors, that could delay residents getting out of the building in an emergency situation. Further interview with the Administrator revealed she had never been through construction in a building as an Administrator, and had not thought about needing a new emergency evacuation plan. However, she stated, in hindsight she should have ensured there was a new emergency evacuation plan specifically addressing the three (3) emergency fire exits affected during the construction. She indicated she should have ensured formal inservicing and education for all staff related to construction and which doors were to be used for alternate evacuation routes. She stated she had not discussed any safety aspects of the construction with the Quality Assurance (QA) Committee meeting held prior to the construction starting; however, indicated she had informed the QA members construction was getting ready to start. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following: 1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director,	F 490	♦ ***Conflict Management training was initiated by the HRD/AIT, SCC, DON, ADON, or SDC on 08/29 and was on-going until 09/12. Topics of discussion were: Conflict management- how to handle it, who to communicate it to if you need help resolving; The Hotline policy and procedure; Attendance policy; Staffing Protocols were also reviewed with the nursing staff only. All those not completed by 09/12 were mailed certified letters that training must be completed prior to working again. Starting the week of 9/12 for 4 weeks, HRD/AIT, SCC, DON, ADON, or SDC have completed stakeholder interviews at random with the nursing staff to address/assist with any stakeholder conflict/teambuilding as necessary.*** ♦ ***Beginning August 02, 2014, five resident skin assessments per day shall be completed by a licensed nurse for residents with BIMS of less than 8. Results will be reviewed by the DON, ADON, SDC, MDSN or WCN daily. Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.***	

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F 490	Continued From page 309 DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating "DO NOT USE" were also placed on the affected doors. 2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had	F 490	***WCN. Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.*** ◆ ***Beginning ~~August 02~~ September 22, 2014, the Administrator, SSD or DON will review weekly, all grievances and allegations of abuse, neglect and misappropriation to assure all steps of the abuse, neglect policy and procedure were completed. Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.*** ◆ ***Beginning September 12, 2014 Residents and families attending care plan conferences shall be asked by the SSD, MDSN, QoLD or Licensed Nurse if there have been any concerns and if grievance process has been initiated and followed. If resident or responsible party does not attend the care plan conference the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain. shall attempt to contact via phone x3 for response. Any***	

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F 490	Continued From page 310 been educated by 07/01/14. The facility did not utilize agency staff. 3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14. Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified. 4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that "Construction is in progress". Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all "temporarily closed" evacuation exits that stated, "STOP-DO NOT USE" by the Maintenance Director on 06/30/14. 5. The Medical Director was notified of the IJ 07/01/14 by the DON. 6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services	F 490	***identified concerns will be investigated by the SCC, Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. Administrator, HRD/AIT, DON, SCC, ADON or SDC will be responsible for re-education and/or disciplinary action up to and including termination shall occur for any failure to follow the grievance process. This will continue until directed otherwise by the QA Committee.*** ♦ ***DON, ADON, SDC and HRD/AIT were in serviced related to staffing protocols (Bluegrass Care and Rehabilitation Center utilizes the ABS (Acuity Based Staffing) plan generated by CMS (Center for Medicare/Medicaid Services). Three (3) days staffing is reviewed in the morning stand up meeting (yesterday's, today's and tomorrow's with Sunday's being included on Friday) M-F. Copies of the three (3) days of staffing sheets will be provided to the DON, ADON, HR Director and Administrator for review in order to review previous days staffing as well as assist in any discrepancies for future schedules) and coverage by SCC and Administrator on August 30, 2014.***	

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F 490	Continued From page 311 and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to "STOP-DO NOT USE". The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14. 7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors "Construction is in process". The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all "temporarily closed" evacuation exits saying "STOP-DO NOT USE" remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed. 8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was	F 490	♦ ***HRD/AIT, MRM, SCC, SDC, ESNS, or WNS inserviced nursing staff on August 31 to September 12, 2014 relative to new staffing protocols, how and to whom to go with conflict as well as education on the corporate hotline, attendance policy and conflict management. Any stakeholder not inserviced by September 12, 2014 will not be permitted to return to work until completed.*** ♦ ***Beginning August 31, 2014 and continuing for 4 weeks, HRD/AIT is interviewing nursing staff relative to existing teamwork, existing conflict, care issues and stakeholder neglect or abuse. This process will continue until instructed otherwise by the QA Committee.*** ♦ ***Beginning September 12, 2014, staffing will be reviewed daily by the Administrator, DON, ADON, SDC, ESNS, WNS, MOD or HRD/AIT the previous days staffing, current day and next day to assure appropriate coverage has occurred.*** ♦ ***An on call schedule has been developed on August 11, 2014 for the DON, ADON, SDC WCN, ESNS and WNS to assure assistance with coverage for call off situations.*** ♦ ***A MOD program (this program is not to be confused with the WNS, This program is comprised of non-clinical managers that will be assigned to weekends to assist the WNS in whatever means possible to secure staffing, etc. or to assist with nonclinical***	

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F 490	Continued From page 312 removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct "spot checks" of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator. 9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use. The State Agency validated the implementation of the facility's AOC as follows: 1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety	F 490	***services (passing ice, making beds, etc.) if and when needed) has been initiated on August 23, 2014 utilizing nonclinical managers consisting of HRD/AIT, DOA, Chaplain, MRM, QoLD, QoLA, DSM, ESD, POD, BOM and SSD for week end assistance with facility and schedule management as needed.*** **Monitoring to assure continuing compliance:** ♦ Beginning August 06, 2014 the POD or PODA shall report all construction activity, plans and results of environmental hazards audits to the QA committee weekly x4 and then monthly for any further recommendations and resolutions. ♦ ~~***Please refer to Ftags 166,224,225,226 and 353 which shall be incorporated herein.***~~ ***Results of the staff, resident and family interviews, skin assessments, call light observations, and incontinence care observations will be reported weekly x4 to the QA committee by the ADON, MDSN, SDC, WCN, SSD, DON, Administrator or HRD/AIT to determine further need for continued education, revision of plan and process improvements. Any allegations of abuse, neglect and misappropriation will be handled immediately and then reviewed at the weekly meeting beginning August 06, 2014.***	

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F 490	Continued From page 313 Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM. Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction. 2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, "due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice". Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding. Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM	F 490	♦ ***Beginning September 02, 2014, reports to QA committee weekly x 4 and them monthly all results of audits, interviews, and observations for any further recommendations or resolutions.*** **Date of Completion:** **09/27/2014**	

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F 490	Continued From page 314 revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person. Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency. 3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes. Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had	F 490		

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F 490	Continued From page 315 performed her education with interviewable residents on 06/30/14 and 07/01/14. Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans. Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes. Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education. 4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged. Observation, on 078/02/14 at 11:32 AM, revealed signs stating "STOP-DO NOT USE" were posted	F 490		

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F 490	Continued From page 316 on the "temporarily closed" evacuation exits. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM. 5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14. 6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director. 7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the "STOP-DO NOT USE" signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification	F 490		

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F 490	Continued From page 317 of the accuracy of the Maintenance audits until the construction process is completed. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log. 8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire. Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing "spot checks" of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her. 9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were	F 490		

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F 490	Continued From page 318 completed accurately and turned into the Administrator. Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party. Reference to F-224, F-225, F-226 2. Review of the facility's policy titled, "Abuse, Neglect and Misappropriation", dated April 2013 revealed abuse and neglect of residents was prohibited. Review of the Policy revealed staff were to be trained on abuse to include what constituted abuse, neglect or misappropriation of resident property. The Policy revealed all allegations of abuse were to be investigated, and the Administrator/designee was to make all reasonable efforts to investigate and address alleged reports, grievances and concerns. Further review revealed Social Services or the Chaplain were to follow up with the resident to monitor his/her emotional well-being after an incident, and families were to be notified of the outcome of the investigation. Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed that morning, he/she had waited for over an hour for someone to respond to his/her call light before, and had "pooped" on himself/herself during the night before as a result	F 490		

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F 490	Continued From page 319 of having to wait for staff's assistance. The resident further stated SRNA #19 had been assigned to his/her care the night before when he/she had "pooped" on himself/herself, and did not change him/her after he/she asked the SRNA to be changed. Resident #26 revealed staff did not changed him/her until day shift reported to work that morning. Interviews with day shift State Registered Nurse Aides (SRNA's), and nurses were conducted revealed other residents were left wet and/or soiled the morning of 07/03/14 who were assigned to SRNA #19 including Residents #5, #27, #28, and #29. Further, staff interviews revealed there was a conflict between SRNA #19 and SRNA #21 who both worked the night shift on the South Unit, stating they did not work together as a team and did not answer call lights for each other. Continued staff interviews revealed this impacted the care the residents received when the two (2) SRNA's were assigned as the only SRNA's on the unit. The facility conducted an investigation which was initiated on 07/03/14 and conducted through 07/07/14 related to Resident #26's concerns regarding the lack of care on the night shift. Review of the investigation revealed there was no documented evidence non-interviewable residents who could not speak for themselves who were cared for by SRNA #19 on 07/03/14, had been assessed, or their families/responsible parties interviewed. Administration failed to ensure these residents were assessed for signs of neglect related to care not provided by night shift staff. Also, as part of the investigation the facility	F 490		

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BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 320 interviewed staff who cared for Resident #26 on 07/03/14. According to the staff interviews, per the investigation, Resident #26 was noted to be very soiled with urine and bowel movement going up to her/his chest and backside, on the morning of 07/03/14, and Resident #29 did not appear as though incontinence care had been performed on the previous shift and the bed was very wet. In addition, staff interviews further revealed there was a conflict between SRNA #19 and SRNA #21 who worked the night shift on the South Unit and they did not work together to assist residents who required two (2) staff to assist with care. The staff interviews from the investigation, also revealed SRNA #9 had complained that her whole group of residents was left wet on the morning of 07/03/14, and LPN #12 and the ADON/Unit Manager of the South Units was aware of SRNA #9's concerns. However, the facility failed to interview SRNA #9 as part of the investigation. Although the staff interviews revealed the conflict between SRNA #19 and SRNA #21, Administration failed to address and investigate this conflict which was impacting the care of the residents. Interview, on 07/23/14 at 5:49 PM and 07/25/14 at 7:20 PM, with the Human Resources (HR) Director, DON, and Social Services Director (SSD) revealed, it would be neglect of residents if incontinence care was not performed timely or when requested. Per the SSD, the investigation initiated on 07/03/14, was focused on Resident #26, due to her/his voiced concerns. The SSD further acknowledged she should have involved nursing in the investigation to assess those residents who could not speak for themselves and were left wet on 07/03/14 including Residents #5, #28, #29, and #27. Continued interview	F 490		