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

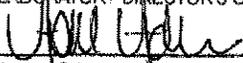
PRINTED: 04/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 000	INITIAL COMMENTS An Abbreviated/Partial Extended Survey investigating KY00021485 and KY00021486 was initiated on 03/31/14 and concluded on 04/10/14. KY00021485 and KY00021486 were substantiated with deficiencies identified. Immediate Jeopardy was identified on 04/03/14 and was determined to exist on 03/02/14 with deficiencies cited at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225 and F-226; and 42 CFR 483.75 Administration, F-490 all at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225 and F-226. The facility was notified of the Immediate Jeopardy on 04/03/14. Based on the findings of the Abbreviated Survey, it was determined the facility had an ineffective system to protect residents from abuse. On 03/02/14, a grievance report was completed by Licensed Practical Nurse (LPN) #4 which documented a statement by Resident #2 revealing he/she had tried to use the phone and LPN #1 "snatched" the phone away, hung it up and told the resident he/she was not allowed to use it. Resident #2 reported LPN #1 said if he/she continued to curse at her she would not give Resident #2 his/her pain medication. Interview and record review revealed the Director of Nursing and the Administrator facility failed to identify the incident as potential abuse and therefore failed to initiate an abuse investigation and report the incident to the appropriate State Agencies. On 03/07/14 at approximately 4:00 AM to 5:00	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bridge Point Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Interim Administrator	(X6) DATE 5/6/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 AM, LPN #6 went into Resident #1's room and was overheard, by facility staff, yelling at the resident related to his/her multiple use of the call light to request pain medication. Interview and record review revealed Certified Nursing Assistant (CNA) # 3 and CNA #7 overheard the LPN and felt it was abuse; however, the CNA's failed to report the abuse incident immediately, as per the facility's abuse policy. The abuse episode was not reported until 03/09/14 allowing LPN #6 to work another entire shift on 03/08/14, before being suspended by the facility. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/08/14, with the facility alleging removal of the Immediate Jeopardy on 04/07/14. The State Agency validated the Immediate Jeopardy was removed on 04/07/14 as alleged with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225 and F-226; and 42 CFR 483.75 Administration, F-490 at a Scope and Severity (S/S) of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors to ensure residents are free from abuse.	F 000	1. The allegation of abuse regarding Resident #2 was reported to the appropriate state agencies LPN #1 was suspended on 4-3-14 by the Administrator and Director of Nursing. The investigation was completed and the final report was submitted to the appropriate state agencies on 4/8/14 by the Administrator. LPN#1 was terminated on 4/14/14 by the Director of Nursing. The allegation of abuse regarding Resident #1 was reported to the appropriate state agencies and the LPN #6 was suspended on 3-9-14. The investigation was completed and the final report was submitted to the appropriate state agencies on 3/14/14 by the Administrator. LPN #6 was terminated on 3/17/14 by the Director of Nursing. Residents' #1 and # 2 have had no additional allegations of abuse.		
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223		5/1/14	

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F 223 | Continued From page 2

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy and grievance forms, it was determined the facility failed to have an effective system to ensure each resident remained free from abuse for two (2) of seven (7) sampled residents (Residents #1 and #2).

On 03/02/14, a Grievance/Concern Report was completed by Licensed Practical Nurse (LPN) #4, which revealed Resident #2 had stated he/she tried to use the phone and LPN #1 "snatched" the phone away, hung it up, and told the resident he/she was not allowed to use it. Continued review of the Grievance/Concern Report revealed Resident #2 reported to LPN #4, he/she had been told by LPN #1 if he/she continued to curse at her the LPN would not give Resident #2 his/her pain medication. Interview and record review revealed the facility failed to investigate the incident as abuse, therefore failed to follow the abuse policy procedures to interview other residents about abuse and/or staff who had potentially witnessed the verbal abuse and, failed to report the abuse to State Agencies. As a result of the facility's failure to investigate the incident as abuse, LPN #1 was only suspended one (1) day, 03/03/14, and allowed to continue working caring for residents placing the residents at risk for potential further abuse by LPN #1.

On 03/07/14 early in the morning, staff witnessed LPN #6 being verbally abusive to Resident #1 room and yelled at the resident due to his/her multiple use of the call light to request pain medication. LPN #6 was overheard telling the resident he/she would not get his/her pain

F 223

2. Director of Nurses, Administrator, and Nurse Supervisors have interviewed alert and oriented residents from 3/13/14 to 4/4/14 to determine if the resident has experienced or witnessed any abuse in the center or any issues with receiving PRN medications timely with corrective action if indicted upon discovery.

Allegations of abuse were reported to the appropriate state agencies within 24 hours of being reported to the interim administrator.

Director of Nurses and Unit Managers completed an assessment of non-interviewable residents from 3/12/14 to 4/4/14 to determine any injury associated with possible abuse with no corrective action required.

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F 223 Continued From page 3
medication any quicker by banging the call light, and also told Resident #1 he/she was acting like a child. Interview with Certified Nursing Assistant (CNA) #3 and CNA #7 revealed they thought what they had witnessed LPN #6 do was abuse but failed to report the abuse incident immediately, as per the facility's abuse policy. The incident was not reported to the facility until evening shift on 03/09/14, and LPN #6 had worked an entire shift on 03/08/14 prior to being suspended by the facility. The facility indicated LPN #6 would be terminated from employment at the facility after the initiation of the Abbreviated Survey.

The facility's failure to have an effective system was in place to ensure each resident remained free from abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 04/03/14 and was determined to exist on 03/02/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/08/14 with the facility alleging removal of the Immediate Jeopardy on 04/07/14. The Immediate Jeopardy was verified to be removed on 04/07/14 as alleged with remaining non-compliance at a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure residents are free from abuse.

The findings include:

Review of the facility's policy titled, "OPS310 KY Abuse Prohibition", dated 07/01/13, revealed verbal abuse was any use of oral, written, or gestured language that willfully included

F 223

3. Director of Nurses, Administrator, Nurse Management, and Human Resources will have provided reeducation by 4/30/14 with the administrative, nursing, therapy, dietary, housekeeping, laundry, and maintenance staff regarding an effective system that ensures each resident remains free of abuse:

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F 223	<p>Continued From page 4</p> <p>disparaging and derogatory terms to residents and mental abuse which included threats of punishment or deprivation. The policy revealed staff who witnessed an incident of suspected abuse was to tell the abuser to stop immediately and report the incident to his/her supervisor immediately who was to report the suspected abuse to the Administrator/designee immediately. Continued review of the policy revealed the employee alleged to have committed the abuse was to be "immediately removed from duty". Further policy review revealed a written report was to be provided "immediately" to the State Agency, not to exceed twenty-four (24) hours. In addition, the policy stated the facility protected residents from further harm during an investigation.</p> <p>1. Review of the facility's grievance form titled, "Grievance/Concern Report", undated, revealed on 03/02/14 Resident #2 reported to LPN #4 he/she tried to use the phone and LPN #1 "snatched" away the phone, hung it up, and told Resident #2 he/she was not allowed to use it. Review revealed LPN #1 told Resident #2 she would not give him/her pain medication if he/she continued to curse at the LPN. Continued review revealed no documented evidence the facility investigated the incident as potential abuse to include interviewing other residents and staff who had witnessed the incident. Further review revealed no documented evidence the facility reported the incident to State Agencies as per facility policy. LPN #1 was only suspended for one (1) day, 03/03/14, by the Director of Nursing Services (DNS) who documented the grievance as resolved on 03/04/14 and allowed LPN #1 to continue working with residents.</p>	F 223	<ul style="list-style-type: none"> Center Abuse policy, Reporting requirements Promise of confidentiality and no fear of retribution. Including stress management strategies for staff. Employee competency validated using the Abuse Prevention post-test. Licensed nurses were provided reeducation 3/14/14 by Director of Nursing regarding the need for licensed nurses to count off controlled medications and relinquish med cart keys with another nurse if leaving the center for lunch or other periods of time to ensure that medications are accessible to residents as needed. 	

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F 223	<p>Continued From page 5</p> <p>Review of LPN #1's "Timecard" punches revealed she worked the dayshift, 7:00 AM to 3:00 PM on: 03/04/14 through 03/06/14; 03/10/14 through 03/13/14; 03/15/14 through 03/17/14; 03/24/14 through 03/27/14; 03/29/14 through 03/31/14; and on 04/02/14, a total of eighteen (18) days, before being suspended on 04/03/14.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident on 06/21/13, with diagnoses which included Paranoid Schizophrenia (a chronic mental illness) Hypertension, Lung Cancer, Other Chronic Pain, Rheumatoid Arthritis, and Pain in Joint, site unspecified. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/05/14, revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident was moderately cognitively impaired.</p> <p>Continued review of the medical chart revealed the March 2014 monthly Physician Orders pain medication orders which included Gabapentin 200 milligrams (MG) capsule by mouth every twelve (12) hours for pain in lower leg joint and Hydrocodone/Acetaminophen 10-325 MG by mouth one tablet every four (4) hours as needed for moderate pain. Review of the Medication Administration Record (MAR) for the date of 03/02/14 revealed Resident #2 received Hydrocodone/Acetaminophen 10-325 MG at 1:00 AM, 7:00 AM, 4:30 PM, and at 8:30 PM. Review of the staffing schedule revealed LPN #1 worked the 7:00 AM to 3:00 PM shift on 03/02/14.</p> <p>Interview, on 04/03/14 at 2:30 PM, with Resident #2 revealed LPN #1 grabbed the phone from his/her ear and "slammed" it down on the receiver.</p>	F 223	<ul style="list-style-type: none"> The Director of Nurses and Administrator were reeducated 3/12/14, 4/4/14 and 4/30/14 by the Manager of Clinical Operations regarding Abuse Policy and reporting requirements. Employees upon hire and/or not working during this timeframe will have education/ reeducation by administrative management to the center's abuse policy, reporting requirements, promise of confidentiality and no fear of retribution and will be repeated annually with all staff. Facility does not use agency staff.

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F 223	<p>Continued From page 6</p> <p>and told the resident he/she had already made two (2) calls. Resident #2 stated he/she had not made two (2) calls and needed to call his/her nephew. According to Resident #2, LPN #1 then said "wait until you want another pain pill". Resident #2 stated he had a lot of pain problems and got pain medication about every four (4) hours. Resident #2 revealed it hurt his/her feelings "real bad" when LPN #1 had done that and after the incident the nurse never talked to him/her again. The resident stated he/she went and told LPN #4 what had happened and LPN #4 said it was a grievance.</p> <p>Interview, on 04/02/14 at 2:39 PM, with Certified Nursing Assistant (CNA) #10 revealed she worked on 03/02/14, and heard Resident #2 being loud. CNA #10 stated she heard LPN #1 tell Resident #2 he/she would not get his/her medicine on time because the resident was not doing what he/she was supposed to do. The CNA stated LPN #1 sounded "aggravated" and "short" when she talked to the resident. CNA #10 stated she had talked to LPN #4 about the incident and the nurse was going to call the DNS.</p> <p>Interview, on 04/09/14 at 3:05 PM, with CNA #11 revealed she worked dayshift on 03/02/14, and thought around 12:00 PM, she witnessed Resident #2 trying to use the phone at the Unit 200 nurse's station. She stated Resident #2 had the phone up by his/her ear and LPN #1, who was at the desk, told Resident #2 he/she was not allowed to use the phone. CNA #11 stated the nurse "grabbed" the phone out of the resident's hand and "slammed" it down on the receiver which startled the CNA. The CNA stated LPN #1 told Resident #2 if he/she tried to use the phone again she was not going to give his/her pain</p>	F 223	<p>4. Administrator and Director of Nurse have assigned supervisors across the 3 shifts daily (includes Saturday and Sunday) to observe staff/resident interaction, and to determine that any allegations are reported immediately to the Administrator as of 4/4/14. Any concerns with staff interaction or allegations identified will be called to the Administrator/DNS by the Shift Supervisor for review to determine any action to be taken including reporting to the state agency if indicated.</p> <p>Administrator, Director of Nursing, and Nurse</p>	
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F 223	<p>Continued From page 7</p> <p>medication. CNA #11 revealed she considered the incident verbal or mental abuse and possibly physical abuse because the nurse "jerked" the phone out of the resident's hand. She stated LPN #4 was also at the nurse's station, and indicated she was going to take care of the incident.</p> <p>Interview, on 04/01/14 at 3:52 PM, with LPN #1 revealed at one point in time Resident #2 was limited to two (2) phone calls a day by his/her sister, who was Guardian at the time, because he/she would call her too much. The LPN stated one (1) time she asked him/her to use the phone later because he/she had been on the phone "a lot". LPN #1 stated Resident #2 got upset and said some curse words then walked away. The LPN further stated "there was nothing said about pain medication". LPN #1 indicated she was not aware of any allegation related to pain medication.</p> <p>Interview, on 04/02/14 at 11:36 AM, with LPN #4 revealed on 03/02/14, around shift change, Resident #2 came down to the 100 Unit nurse's station to use the phone. She stated Resident #2 also reported LPN #1 "snatched" the phone out of his/her hand and told the resident he/she could not use it anymore. LPN #4 stated Resident #2 reported he/she was upset about phone incident and "cussed" at the nurse, who then told the resident she would not give him/her his/her pain medication if he/she kept talking to her like that. LPN #4 revealed she then went and spoke to LPN #1 about what Resident #2 reported and told LPN #1 services could not be withheld because of the way a resident spoke to them. She stated LPN #1 then got upset and went out to the nurse's station and said out loud, no one was going to talk to her like that and if they (residents)</p>	F 223	<p>Supervisors will interview 5 employees from all departments weekly x4 weeks and then monthly x3 months then as determined by the monthly Quality Assurance /Performance Improvement Committee to determine staff understanding of the abuse policy, reporting allegations to the Administrator immediately, and that allegations or statements are kept confidential with no fear of retribution for reporting. Concerns identified will be addressed upon discovery.</p> <p>Administrator, Director of Nurses and Nurse Supervisors will interview 5 residents weekly x4 weeks and monthly x3 months to determine any issues with staff treatment or abuse and any issues with withholding of medication. Concerns identified will be addressed upon discovery.</p>	

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F 223	Continued From page 8 did she was not going to give them their pain medication. Continued interview with LPN #4 revealed she had called the DNS about the incident and was told the DNS would take care of it. Interview with Social Worker (SW) #1 on 04/03/14 at 1:57 PM and 2:53 PM, revealed the Ombudsman had reported to her there had been a phone issue concerning Resident #2 and said something about pain medication. She stated around 03/03/014 or 03/04/14 after the Ombudsman's report, she talked to the resident about phone usage and the DNS talked to him/her about pain medication. The SW stated on 04/03/14 she again interviewed Resident #2, about the incident on 03/02/14. The SW stated Resident #2 informed her the nurse told him/her she was not going to give his/her pain medication if he/she used the phone again. She stated based on her interview with Resident #2 on 04/03/14, it sounded like it was an abuse allegation. In an additional interview with SW #1 on 04/08/14 at 6:02 PM, she stated she had first read the grievance sometime between the week of 03/03/14 through 03/08/14, and was concerned because the content stated the nurse had "snatched" the phone away from Resident #2 and, the nurse told the resident if he/she continued to curse at her she would not give his/her pain medication. The SW revealed she talked to the Administrator and the DNS, who are in charge of abuse investigations, about the grievance, her concern and what to do next. She stated she could not remember what all was discussed or if she identified the grievance as an allegation of abuse or only a concern. Interview, on 04/02/14 at 12:30 PM and on	F 223	Administrator and/or Social Services, or Shift Supervisors will review grievances, complaints and allegations daily (includes Saturday and Sunday) times 4 weeks then as determined by the monthly Quality Assurance /Performance Improvement Committee to determine that Abuse allegations are reported timely, resident is protected from further potential abuse as per the Abuse Policy and that investigations are thoroughly completed. Concerns identified will be addressed upon discovery.		

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(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 223	Continued From page 9 04/03/14 at 5:34 PM, with the DNS revealed the Grievance/Concern Report form was in her mailbox on 03/03/14, and she as indicated by LPN #4 was not called by phone. The DNS stated she thought it was an abuse incident when she read the statement. However, on 03/03/14 she talked to Resident #2, who was alert and oriented, about the incident and the resident denied the nurse had threatened not to give him/her the pain medication. The DNS stated she went by what the resident said, and did not think it was abuse after all. She called LPN #1 and told her she had to take courses on customer service, resident rights, and the facility's abuse policy before returning to work. Interview, on 04/02/14 at 1:53 PM and on 04/08/14 at 6:46 PM, with the Administrator revealed she had not seen the grievance until "about" 03/06/14 when she got it out of her mailbox, but should have been made aware immediately. The Administrator stated she had previously discussed the incident with the DNS and talked about a nurse and Resident #2's phone usage; however, she did not believe they talked about the medication allegation. The Administrator stated once she saw the Grievance/Concern Report form content she should have recognized the threat to withhold pain medication as mental abuse or even neglect, removed the alleged perpetrator from resident care and conducted a thorough investigation of the allegation. The Administrator indicated there was a concern for potential further abuse of residents when an employee who allegedly committed abuse was allowed to continue working. She stated as the Administrator she was ultimately responsible for the protection of the residents.	F 223	5. The Administrator will bring trends identified from the daily review of allegations, complaints and grievances, and employee and resident interviews to the monthly Quality Assurance /Performance Improvement Committee x4 months for further review and recommendations. 6. Completion date 5/1/14.		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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F 223	Continued From page 10 Interview, on 04/09/14 at 4:13 PM, with the Medical Director revealed the facility reported the incident involving Resident #2 to him; however, did not indicate when he was notified. He stated it was wrong for the nurse to threaten not to give the pain medication to Resident #2. The Medical Director further stated there was no excuse for the nurse to have done that. He indicated the facility should have investigated the allegation. 2. Review of the facility's final report to the State Agency dated 03/14/14, revealed it noted a grievance form was turned into the facility by Resident #1's family member on 03/09/14, stating a nurse (LPN #8) had spoken to the resident unprofessionally. Review of the final report revealed Resident #1 reported on night shift during the early morning hours of 03/07/14, the resident had used her call light multiple times and banged it on the table to get staff's attention for his/her medication and was told the nurse was on break. The final report indicated Resident #1 was interviewed and told staff she had began requesting the medication at 2:45 AM, and received it at approximately 4:00 AM. The final report noted when the nurse entered the resident's room she told the resident he/she was going to listen to what she said and proceeded to tell the resident he/she was bothering other residents by making so much noise. Review of the final report revealed in interview Resident #1 stated the nurse told him/her this behavior would not help the resident get pain medication any quicker. Additionally, the report noted interviews with staff revealed the nurse was "yelling" at Resident #1 and, could be heard at the nurse's station saying to the resident that hitting the bedside table would not get his/her assistance	F 223		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 223	<p>Continued From page 11</p> <p>any faster. Further review of the final report revealed another employee stated LPN #6 came back from the resident's room and told other employees she had instructed the resident to stop ringing his/her call light every few minutes and then proceeded to call the resident a "child" to the employees present. In addition, review of the final report revealed the facility substantiated abuse on the part of LPN #6 and she was to be terminated from employment at the facility.</p> <p>Review of LPN #6's "Timecard" punches revealed she worked on 03/07/14 until 7:34 AM and also worked on 03/08/14 from 11:00 PM until 8:18 AM on 03/09/14.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 01/24/14, with diagnoses which included Chronic Airway Obstruction, Chronic Pain, End Stage Renal Disease, and Tracheostomy. Review of the Quarterly MDS Assessment dated 03/31/14, revealed the facility assessed the resident to be cognitively intact. Continued review of the MDS revealed the resident was assessed by the facility to have almost constant pain which effected the resident's sleep. Continued review of the medical record revealed the March 2014 monthly Physician Orders, included Percocet 5-325 MG PRN 1-2 tablets every six (6) hours for pain which started on 02/04/14. Review of Resident #1's March 2014 MAR revealed the resident received the PRN Percocet on 03/07/14 at 4:00 AM and again at 6:30 PM.</p> <p>Interview, on 04/01/14 at 2:16 PM and on 04/02/14 at 4:15 PM and 5:14 PM, with Resident #1 revealed the resident did not speak, but mouthed words or shook his/her head, as he/she</p>	F 223		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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F 223	<p>Continued From page 12</p> <p>had a tracheostomy (trach). Resident #1 stated staff was all nice but one (1) nurse and reported a nurse on night shift had yelled at him/her and it took three (3) hours to get pain medication after she requested the medication. Resident #1 indicated the nurse was upset with her/him banging the call light and the nurse said he/she was acting like a kid. The resident mouthed it felt like she was a child when the nurse yelled and was scared.</p> <p>Interview, on 04/02/14 at 8:55 AM, with CNA #7 revealed she cared for Resident #1 and reported on night shift of 03/06/14 the resident wanted pain medication and rang his/her call light multiple times, thinks about ten (10) times). CNA #7 stated Resident #1 banged the light on the table, and described the resident as appearing aggravated while the nurse was out on lunch break for over an hour. The CNA stated she was at the nurse's station, multiple rooms away from Resident #1's room, when the nurse came back answered the call light and was very loud. CNA #7 reported she heard the nurse "banging on the table" and informing the resident he/she would not get the medication any quicker by banging on the table. According to CNA #7, she went into Resident #1's room after the nurse had left and apologized to the resident for the way the nurse had acted and she stated the resident was upset. The CNA revealed she should have reported the incident immediately, but did not because she was scared if it got back to the nurse.</p> <p>Interview, on 04/02/14 at 8:55 AM and 04/09/14 at 6:58 PM, with CNA #3, who worked night shift on 03/06/14, revealed Resident #1 had used the call light approximately six (6) times while the nurse was on lunch break for about an hour and</p>	F 223		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 223 Continued From page 13

when the nurse returned she told her the resident needed pain medication. The CNA stated when she came back from break she heard LPN #6 at the nurse's station stating she had told Resident #1 he/she acted like a child by banging the call light. CNA #3 stated she estimated the incident occurred around 4:00 AM and the resident seemed upset when the CNA went into the room after the incident. The CNA revealed the nurse should not have called the resident a child and thought it was mental/verbal abuse, indicating she would be upset if someone said that to her mother.

Interview, on 04/10/14 at 3:54 PM, with RN #4/Weekend Supervisor revealed on second shift on 03/09/14 at about 8:00 PM, one (1) of the nurses talked to her about the incident involving Resident #1 and she went and talked to the resident. RN #4/Weekend Supervisor stated Resident #1 had a trach and using the call light and banging the call light was his/her voice. She stated Resident #1 reported he/she was banging the call light on the table to get attention because he/she wanted a pain pill and LPN #6 screamed at him/her and told the resident he/she annoyed other residents by making the noise. She stated she also talked to CNA #7 who reported LPN #6 had yelled so loud she could hear the nurse at the nurse's station. RN #4/Weekend Supervisor stated CNA #7 told her she was afraid the nurse would be mad at her if she reported the incident.

Interview, on 04/01/14 at 5:54 PM, with SW #1 revealed when she initially followed up with Resident #1 on 03/13/14, regarding the grievance the resident reported a nurse had raised her voice, was "curt" and "being nasty" to him/her. The SW stated the resident started crying and

F 223

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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F 223	<p>Continued From page 14</p> <p>she was unable to understand Resident #1. She stated on 03/17/14, she spoke to Resident #1 again regarding the grievance and the way the resident described the incident she would consider it abuse.</p> <p>Interview with the DNS on 04/02/14 at 12:30 PM and on 04/04/14 at 5:00 PM, revealed the incident occurred on nightshift of 03/06/14 to the morning of 03/07/14. The DNS stated she was not made aware of the incident until 03/09/14, when Resident #1 and his/her family had spoken to evening shift staff about it and they called her. She stated LPN #6 was suspended and did not work the night of 03/09/14, but had worked nightshift on 03/08/14, from 11:00 PM to 7:00 AM on 03/09/14. The DNS stated from the facility's investigation they had determined staff were aware on 03/07/14, but did not report the abuse. She indicated if she had known about the incident when it occurred the nurse would have been suspended immediately. However, she stated the nurse had worked on 03/08/14, and there was an opportunity for more abuse to that resident and other residents.</p> <p>Interview, on 04/08/14 at 6:46 PM, with the Administrator revealed the employee alleged to have committed the abuse, towards Resident #1, worked another shift before Administration became aware of the allegation. She stated, however some staff had been aware of the incident when it happened and should have reported the allegation immediately. She indicated the nurse worked another shift and there was potential for another abuse incident before the nurse was suspended. The Administrator stated if she had been made aware of the incident she would have come in</p>	F 223		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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F 223	<p>Continued From page 15</p> <p>immediately, started the investigation, and suspended the nurse immediately.</p> <p>On 04/02/14 at 10:39 AM an attempt was made to contact LPN #6 by phone; however, the attempt was unsuccessful and there was no way to leave a message.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 04/08/14 which alleged removal of the Immediate Jeopardy (IJ) effective 04/07/14. Review of the AOC revealed the facility had implemented the following:</p> <ol style="list-style-type: none"> 1. The facility's DNS, Administrator and Nurse Supervisors interviewed all interviewable residents to determine if they had experienced or witnessed any abuse in the facility or any issues with receiving PRN medications timely or threatening to have their medication withheld. The facility completed the interviews 03/14/14 and on 04/04/14. 2. The facility's DNS and Nurse Supervisors completed assessments of all non-interviewable residents to determine any injury associated with possible abuse. The facility completed the assessments on 03/14/14 and on 04/04/14. 3. The DNS and Administrator were re-educated to the Abuse Policy, the timely reporting requirements and completion of a thorough investigation by the MCO on 03/12/14 and on 04/03/14. 4. The facility's DNS, Administrator and Nurse Supervisors educated administrative, therapy, dietary, housekeeping, laundry, and maintenance 	F 223			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2014
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
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F 223	<p>Continued From page 16</p> <p>staff on the facility's abuse policy, reporting requirements, promise of confidentiality, and no fear of retribution. Staff was also inserviced on stress management. Employees completed the Abuse Prevention post-test. The facility completed the inservices on 03/14/14 and again on 04/04/14.</p> <p>5. The facility's DNS and Nurse Supervisors educated licensed nurses to count off controlled medications and relinquish med cart keys with another nurse if leaving the facility for lunch breaks or other periods of time to ensure medications were accessible to administer to residents as needed. The facility completed the inservices on 03/14/14.</p> <p>6. The facility's DNS and Administrator were responsible for terminating the nurse involved in the allegation of abuse for Resident #1 and reporting the nurse to the Kentucky Board of Nursing. The facility completed the action on 03/14/14.</p> <p>7. The two (2) staff members who heard the incident involving Resident #1, but did not report the allegation received disciplinary action by the DNS and Administrator. The facility completed the action on 03/14/14.</p> <p>8. A Performance Improvement (PI) Meeting, to include the Administrator, DNS and Medical Director was held to discuss the late reporting of the allegation of abuse related to Resident #1 and the plan to correct this. The facility completed this action on 03/14/14.</p> <p>Additionally, a Performance Improvement Meeting, to include the Administrator, DNS and</p>	F 223			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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F 223	Continued From page 17 Medical Director, was held to discuss the late reporting of the allegation of abuse related to Resident #2, the immediate Jeopardy citations, root cause and plan of correction. The facility completed this on 04/04/14. 9. The nurse identified in the allegation of abuse for Resident #2 was suspended on 04/03/14. The facility identified the DNS and Administrator as being responsible for the action. The facility completed the action on 04/03/14. 10. The initial report of the allegation involving Resident #2 was submitted to the State Agencies on 04/03/14, the persons assigned responsibility were the DNS and Administrator. The facility completed the action on 04/03/14. 11. The facility's DNS and Administrator was responsible for interviewing Resident #2 regarding the allegation of abuse reported on 03/02/14. The facility completed the action on 04/04/14. 12. The facility's DNS, Administrator and Nursing Supervisors were responsible for interviewing the sister of Resident #2 regarding the allegation of abuse reported on 03/02/14. The facility completed the action on 04/04/14. 13. The facility's DNS, Administrator and Nurse Supervisors were responsible for interviewing employees who worked 7:00 AM to 3:00 PM on 03/02/14 regarding the allegation of abuse related to Resident #2. The facility completed the interviews on 04/05/14. 14. The facility's DNS and Nurse Supervisors were responsible to enter the allegation of abuse	F 223		

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

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

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--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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(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 223	<p>Continued From page 18 for Resident #2 into the Risk Management System (RMS). The facility completed the action on 04/04/14.</p> <p>15. The facility's DNS, Nurse Supervisors and Administrator were responsible to provide education to new hires on the facility's abuse policy, reporting requirements, promise of confidentiality, and no fear of retribution during orientation. This was an ongoing action. The facility did not use agency staff.</p> <p>16. The facility was to assign supervisors on each shift to monitor staff and resident interactions and to determine any allegations of abuse were reported immediately to the Administrator. The facility's Administrator and DNS were responsible to implement the action and the facility completed on 04/04/14.</p> <p>17. The facility was to implement monitoring actions to include interview of five (5) employees weekly for four (4) weeks and then monthly for three (3) months to determine: staff understood the facility's abuse policy; understood reporting allegations to the Administrator immediately; and understood allegations or statements were kept confidential and there was no fear of retribution for reporting. Any concerns were to be addressed at the time of interview. The facility identified the DNS, Nurse Supervisors and Administrator as being responsible for the audits which were ongoing.</p> <p>18. The facility was to implement monitoring actions to include interview of five (5) residents weekly for four (4) weeks and then monthly for three (3) months to determine any issues with staff treatment or abuse and any issues with</p>	F 223		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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F 223	<p>Continued From page 19</p> <p>withholding of medication. Any concerns identified were to be addressed at that time. The facility identified the Administrator as being responsible for he audits and they were ongoing.</p> <p>19. The facility was to implement monitoring actions to include an audit of all abuse investigations to determine that abuse allegations were reported timely as per the abuse policy and the investigations were thoroughly completed. Any concerns identified during the audit were to be addressed at that time. The facility identified the Administrator as being responsible for the audits and they were to be ongoing.</p> <p>20. The findings of the monitoring identified above were to be reported to the Performance Improvement Committee monthly for four (4) months for further review and recommendation. The Administrator and DNS were responsible and this was to be ongoing.</p> <p>21. The facility was to perform an audit on abuse allegations identified for the prior thirty (30) days, 03/06/14 through 04/06/14, to assure a thorough investigation was completed and any abuse was reported timely as per the facility policy. The person responsible was the MCO and the facility was to complete this on 04/07/14.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Interview and review of the facility's AOC implementation documentation for Resident #1 and Resident #2, with the DNS on 04/10/14 at 10:37 AM, 12:13 PM and at 1:16 PM, revealed the facility used a Resident Census Report to identify all interviewable residents. The resident</p>	F 223			

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

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

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F 223	<p>Continued From page 20</p> <p>interviews were performed by the DNS and Nursing Supervisors which included Unit Managers. Reviewed the documented resident interviews all completed by 03/14/14 and 04/04/14.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 04/10/14 at 4:27 PM, and RN #5/100 Unit Manager on 04/10/14 at 4:48 PM revealed resident interviews were performed as per the AOC.</p> <p>Interview on 04/10/14, with Resident #1 at 12:58 PM; Resident #2 at 10:19 AM; Unsampld Resident A at 5:05 PM; Unsampld Resident B at 4:49 PM; and Unsampld Resident C at 5:10 PM revealed they were all interviewed by facility staff two (2) different times recently about abuse and medications.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she was in charge of the AOC plan to make sure everything was completed as indicated and verified all the resident interviews were completed by the 03/14/14 and 04/04/14 as noted on the AOC.</p> <p>2. Interview and review of the facility's AOC implementation documentation with the DNS on 04/10/14 at 10:37 AM, 12:13 PM and at 1:16 PM, revealed the facility used a Resident Census Report to identify all non-interviewable residents. The DNS stated they had two (2) staff present for skin assessments and no problems were identified indicating abuse, such as, bruises, scratches, any type of redness or any signs they were not getting care. Review and interview with the DNS revealed the skin assessments were performed by the DNS and Nursing Supervisors</p>	F 223			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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F 223	<p>Continued From page 21 on 03/13/14, 03/14/14 and again on 04/04/14 with no issues identified.</p> <p>Interview with the ADON on 04/10/14 at 4:27 PM and RN #5/100 Unit Manager at 4:48 PM, revealed skin assessments were performed on non-interviewable residents.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she had verified all skin assessments of non-interviewable residents were completed by 03/14/14 and 04/05/14 as noted on the AOC with no issues identified.</p> <p>3. Review of a documented Inservice on 03/12/14 and 04/03/14 revealed the DNS and Administrator were re-educated on the facility's abuse policy and reporting requirements by the MCO.</p> <p>Interview with the DNS on 04/10/14 at 12:13 PM, and the Administrator on 04/10/14 at 5:29 PM, revealed both had received an inservice on the abuse policy and reporting requirements on 03/12/14 and 04/03/14 by the MCO.</p> <p>4. Interview and review of the facility's AOC implementation documentation for Resident #1 and Resident #2, with the DNS on 04/10/14 at 10:37 AM, at 12:13 PM and at 1:16 PM, revealed the facility used a master list of employees to inservice all staff on 03/10/14 thru 03/14/14 and on 04/03/14 thru 04/04/14. The DNS stated staff inservices included review of the abuse policy which included examples of abuse and reporting, investigations and reporting were confidential, stress management, and abuse post-test. She further stated inservices were performed by the Administrative team which included herself, the Administrator and Nursing Supervisors. The</p>	F 223		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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F 223 Continued From page 22
DNS stated staff who were not present were contacted by phone and given the inservice on the abuse policy and stress management. She indicated staff who the facility was unable to contact by phone were sent the inservice education by certified mail. The list of staff who were sent the inservice education by certified mail and the certified mail receipts were reviewed. Interview with the DNS revealed when the staff who were not present at the inservice came in to work they went over the post test and signed inservice sheets prior to beginning work. She stated the inservices were performed by the Administrative team which included herself, the Administrator and Nursing Supervisors.

Review of the AOC implementation documentation revealed a master list of employees which showed staff were inserviced from 03/10/14 through 03/14/14 and on 04/03/14 and 04/04/14, on the abuse policy, reporting requirements, promise of confidentiality, no fear of retribution and stress management. The inservice material and post-tests completed by employees after the inservicing were reviewed.

Interview on 04/10/14 with the ADON at 4:27 PM; RN #4/Weekend Supervisor at 4:08 PM; Activities Director at 2:44 PM; the Employee Benefits and Payroll Coordinator at 3:13 PM; the Maintenance Director at 3:39 PM; and RN #5/100 Unit Manager at 4:48 PM revealed they had inserviced staff on the facility's abuse policy and stress management in March and April.

Staff interviews on 04/09/14 with LPN #10 at 5:22 PM; CNA #18 at 5:30 PM; LPN #11 at 5:41 PM; CNA #14 at 5:51 PM; CNA #3 at 6:55 PM; and, on 04/10/14 with LPN #12 at 7:30 AM; LPN # 13 at

F 223

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2014
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042		
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F 223	<p>Continued From page 23</p> <p>7:50 AM; LPN # 14 at 7:55 AM; Dietary Aide #1 at 2:05 PM; Housekeeping #1 at 2:18 PM; Dietary Aide #2 at 2:27 PM; Housekeeping #2 at 2:32 PM; Activities Director at 2:44 PM; Maintenance #1 at 2:55 PM; Laundry #1 at 3:04 PM; Employee Payroll and Benefits Coordinator at 3:13 PM; Occupation Therapist (OT) #1 at 3:21 PM; Physical Therapy Assistant (PTA) #1 at 3:26 PM; CNA #16 at 3:33 PM; Maintenance #2 at 3:39 PM; CNA #17 at 3:47 PM; RN #4/Weekend Supervisor at 4:08 PM; and LPN #15 at 4:17 PM revealed all indicated they had received inservices on abuse in March and April which included the types of abuse, how and when to report abuse, confidentiality/retribution, and stress management.</p> <p>5. Interview and review of the facility's AOC implementation documentation for Resident #1, with the DNS on 04/10/14 at 12:13 PM and at 1:16 PM, revealed the facility used a master list of nurses identified as receiving inservice education on 03/13/14 and 03/14/14 on counting controlled medications in the medication carts and giving the medication cart keys to another nurse before leaving the facility for lunch breaks. She stated the inservices were performed by herself and the Nursing Supervisors.</p> <p>Interview on 04/10/14 with DNS and ADON at 4:27 PM, RN #4/Weekend Supervisor at 4:08 PM, Activities Director at 2:44 PM, and RN #5/Unit Manager 100 at 4:48 PM revealed they inserviced staff on abuse in March and when applicable nursing staff on med cart.</p> <p>Staff interviews on 04/09/14 with LPN #10 at 5:22 PM; LPN #11 at 5:41 PM; and on 04/10/14 with LPN #12 at 7:30 AM; LPN #13 at 7:50 AM; LPN</p>	F 223			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
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F 223	<p>Continued From page 24</p> <p>#14 at 7:55 AM; RN #4/Weekend Supervisor at 4:08 PM; and LPN #15 at 4:17 PM revealed all indicated they had received inservices on counting controlled medications in the medication carts and on giving the medication cart keys to another nurse prior to leaving the facility for lunch breaks in March.</p> <p>Interview with the Administrator, on 04/10/14 at 5:29 PM, revealed nurses were inserviced staff as indicated on the AOC in March.</p> <p>6. Review of the facility's report of LPN #6 to KBN revealed the nurse was reported on 03/21/14. Personnel record review revealed LPN #6 was terminated from employment.</p> <p>Interview with the DNS on 04/10/14 at 1:16 PM and the Administrator at 5:29 PM, revealed LPN #6 was terminated on 03/17/14 per the AOC and reported to KBN by the DNS.</p> <p>7. Interview with the DNS on 04/10/14 at 1:16 PM and the Administrator at 5:29 PM, revealed the two (2) staff who did not report the abuse of Resident #1 received final written warnings by the DNS for not reporting timely. The final written warnings for CNA #3 and CNA #7 were reviewed.</p> <p>Interview with CNA #7 on 04/02/14 at 8:55 AM and CNA #3 on 04/09/14 at 6:58 PM, revealed they were counseled by the facility about reporting abuse sooner.</p> <p>8. Review of the PI meeting sign in sheets dated 03/14/14 and 04/04/14, revealed it was signed by Administrator, DNS and Medical Director.</p> <p>Interview with the Medical Director on 04/09/14 at</p>	F 223		

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

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

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042	
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F 223	<p>Continued From page 25</p> <p>4:13 PM, revealed he attended the PI meeting in March about the allegation of abuse involving Resident #1 and a nurse. He stated they discussed what happened and an action plan on how to prevent it from happening again. Additionally, the Medical Director stated he attended the PI meeting in April regarding the allegation of abuse involving Resident #2 and in the meeting they had discussed the Immediate Jeopardy related to the abuse incident and the action plan to prevent reoccurrence.</p> <p>Interview with the DNS on 04/10/14 at 12:13 PM and the Administrator at 5:29 PM, revealed they attended the March and April PI meeting with the Medical Director and discussed the allegation of abuse and action plan related to Resident #1 and Resident #2 and also discussed the Immediate Jeopardy and action plan in April.</p> <p>9. Review of LPN #1's "Timecard" punches revealed the nurse clocked out on 04/03/14 at 2:04 PM.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM and Administrator at 5:29 PM revealed LPN #1 was suspended on 04/03/14.</p> <p>10. Review of the initial faxed report sent to the State Survey Agency regarding the 03/02/14 abuse allegation involving Resident #2 and LPN #1 was sent on 04/03/14 by the Administrator.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM confirmed she sent the faxed report on 04/03/14.</p> <p>11. Review of an interview with Resident #2 was completed on 04/04/14 as indicated on the AOC</p>	F 223		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042
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F 223	<p>Continued From page 26 plan.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM revealed they interviewed Resident #2 on 04/04/14, and he/she confirmed the nurse threatened not to give the resident pain medication.</p> <p>Interview with Resident #2 on 04/10/14 at 10:19 AM, revealed the DNS and Administrator talked to him/her about the phone incident and pain medication.</p> <p>12. Review of the facility's documented interview with Resident #2's sister revealed it was performed on 04/04/14 as indicated on the AOC.</p> <p>Interview with the Administrator on 04/10/14 at 5:29 PM, revealed she interviewed Resident #2's sister on 04/04/14, and she asked about the incident. The Administrator stated the sister already knew about the allegation, but thought the nurse was trying to limit the resident's phone calls to her as requested. Interview with DNS on 04/10/14 at 12:13 PM revealed the Administrator interviewed the resident's sister.</p> <p>13. Review of witness statements of employees who worked from 7:00 AM to 3:00 PM on 03/02/14 were reviewed by comparison with the 03/02/14 dayshift schedule.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM and 12:13 PM and the Administrator at 5:29 PM, revealed all staff who worked dayshift on 03/02/14 were interviewed mostly by the DNS and were asked did you hear a nurse yell or scream at a resident and did you hear a nurse threaten to withhold medication.</p>	F 223		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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F 223	Continued From page 27 Interview with the ADON on 04/10/14 at 4:27 PM, revealed she interviewed some of the staff who worked on 03/02/14 about the allegation. Interview with CNA #11 on 04/09/14 at 3:05 PM and with LPN #4 at 3:15 PM, revealed they had worked on 03/02/14 and were interviewed by the facility about the event on 04/04/14. 14. Interview with the DNS on 04/10/14 at 10:37 AM and review of the facility's AOC implemented for Resident #2 revealed the facility entered the allegation of abuse for Resident #2 into the Risk Management System on 04/04/14. 15. Review of the AOC documentation revealed the facility had new employees who were inserviced on 04/07/14 on the abuse policy, reporting requirements, promise of confidentiality and no fear of retribution. Interview with the DNS on 04/10/14 at 10:37 AM, revealed the facility had several newly hired staff who were interviewed on 04/07/14 regarding their inservice. Interview with the Administrator 04/09/14 at 1:28 PM, revealed the facility does not use agency staff. 16. Review of the facility's work schedule 04/04/14 through 04/06/14 revealed the facility had supervisors on each shift. Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed supervisors were assigned to each shift to monitor for abuse and were supposed to monitor	F 223			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042	
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F 223	<p>Continued From page 28</p> <p>interactions between residents and employees to ensure they were appropriate. They indicated if there was an allegation reported to the supervisor it was to be reported immediately to the Administrator.</p> <p>Interviews on 04/10/14 with the Maintenance Director at 3:39 PM; the ADON at 4:27 PM; RN #4/100 Unit Manager at 4:48 PM; Employee Benefits and Payroll Coordinator at 3:13 PM; and Activities Director at 2:44 PM revealed they all had a list of shifts and they picked up different shifts to observe and supervise interactions of employees and residents and if a suspected allegation of abuse was identified they were to call the DNS and Administrator immediately. The staff indicated no abuse allegations had been identified.</p> <p>17. Reviewed the audit tool which was to be utilized for employee abuse interviews.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the facility had implemented audits to interview five (5) employees weekly for four (4) weeks and then monthly for three (3) months to determine if staff understood the abuse policy and reporting of all allegations of abuse. Continued interview revealed audits had been initiated and would be done by Administrator, DNS or Nursing Supervisors Monday through Friday, and staff would be re-educated if concerns were identified.</p> <p>Interview, on 04/10/14 at 4:27 PM, with the ADON revealed she had interviewed some employees for the abuse audits and they were supposed to do five (5) employees each week. The ADON indicated if she identified a problem during the</p>	F 223		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042
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F 223	<p>Continued From page 29</p> <p>audit she was to address it at that time; however had not identified a problem in her abuse audits.</p> <p>18. Reviewed the audit tool which was to be utilized for resident interviews.</p> <p>Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the facility had implemented the audits to interview five (5) residents weekly for four (4) weeks and then monthly for three (3) months to determine any issues with staff treatment and any withholding of medication. Continued interview with the DNS and Administrator revealed audits had been initiated and residents were to be interviewed by the Administrator, DNS and Nursing Supervisors Monday through Friday.</p> <p>Interview on 04/10/14 at 4:27 PM, with the ADON revealed she had performed resident interviews for the audits and they were supposed to do five (5) per week. She indicated if a concern was identified it was to be addressed at the time of interview; however, had not identified any concerns in her resident interview audits.</p> <p>19. Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the facility did not have a specific form for auditing the abuse investigation but the Administrator would be performing audits on all abuse investigations to determine if the allegations were reported timely, investigations were thoroughly completed and the initial report was sent to the State Survey Agency in twenty-four (24) hours and the five (5) day follow up was sent in timely. Continued interview with the DNS and Administrator revealed any concerns would be addressed at that time.</p>	F 223		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPPOINT DRIVE FLORENCE, KY 41042	
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F 223	Continued From page 30 20. Interview with the DNS on 04/10/14 at 10:37 AM and the Administrator at 5:29 PM, revealed the audit data would be presented to the monthly PI Committee meetings by the Administrator or DNS for four (4) months as indicated in the AOC. Continued interview with the DNS and Administrator revealed they have not yet had the monthly PI Committee meeting. 21. Interview, on 04/10/14 at 1:40 PM, with the MCO revealed her role was to review prior abuse investigations from 03/06/14 to 04/06/14, to ensure the investigations were done, were thorough and incidents were reported in a timely manner per the facility's abuse policy. Continued interview with the MCO revealed she had audited five (5) incidents, including those involving Resident #1 and #2, and reported those were the only problematic events.	F 223		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	1. The allegation of abuse regarding Resident #2 was reported to the appropriate state agencies LPN #1 was suspended on 4-3-14 by the Administrator and Director of Nursing. The investigation was completed and the final report was submitted to the appropriate state agencies on 4/8/14 by the Administrator. LPN#1 was terminated on 4/14/14 by the Director of Nursing.	5/1/14

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

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F 225	<p>Continued From page 31</p> <p>including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and grievance forms, it was determined the facility failed to have an effective system to ensure alleged incidents were immediately reported to Administration, thoroughly investigated and reported to State Agencies, and failed to protect residents from further potential abuse for two (2) of seven (7) sampled residents (Residents #1 and #2). (Refer to F-223)</p> <p>Licensed Practical Nurse (LPN) #4 completed a Grievance/Concern Report on 03/02/14, after Resident #2 reported to her LPN #1 had "snatched" the phone away from him/her, hung it</p>	F 225	<p>The allegation of abuse regarding Resident #1 was reported to the appropriate state agencies and the LPN #6 was suspended on 3-9-14. The investigation was completed and the final report was submitted to the appropriate state agencies on 3/14/14 by the Administrator. LPN #6 was terminated on 3/17/14 by the Director of Nursing.</p> <p>Residents' #1 and #2 have had no additional allegations of abuse.</p> <p>2. Director of Nurses, Administrator, and Nurse Supervisors have</p>	

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

PRINTED: 04/24/2014
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2014
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F 225	Continued From page 32 up, and informed the resident he/she was not permitted to use it. Resident #2 indicated to LPN #4, LPN #1 had threatened not to give his/her pain medication if he/she continued to curse at her. The facility considered this incident a grievance, and therefore it was not thoroughly investigated to include interviews with other residents or staff and was not reported immediately to the Administrator and State Agencies. The the grievance investigation conducted on 03/03/14 by the Director of Nursing Services (DNS) only included interviews with Resident #2 and LPN #1, who was suspended 03/03/14. The DNS resolved the grievance on 03/04/14 and allowed LPN #1 to return to work. Therefore, the facility failed to protect residents from further potential abuse by LPN #1. Additionally, staff witnessed an incident of verbal abuse by LPN #6 who yelled at Resident #1 in the early morning of 03/07/14, due to his/her using the call light multiple times to request pain medication. Staff heard LPN # 6 tell Resident #1 he/she was acting like a child and would not get his/her pain medication any quicker by banging the call light. Certified Nursing Assistant (CNA) #3 and CNA #7 were witnesses to the incident; however, failed to immediately report the incident. The facility's Administration was not notified until the evening shift on 03/09/14, therefore an investigation was not conducted immediately after the incident, residents were not protected from further potential abuse, and the incident was not reported to State Agencies until 03/10/14. Based on the above findings, it was determined the facility's failure to thoroughly investigate alleged incidents of abuse to prevent further potential abuse, and failure to ensure alleged	F 225	interviewed alert and oriented residents from 3/13/14 to 4/4/14 to determine if the resident has experienced or witnessed any abuse in the center or any issues with receiving PRN medications timely with corrective action if indicted upon discovery. Allegations of abuse were reported to the appropriate state agencies within 24 hours of being reported to the interim administrator. Director of Nurses and Unit Managers completed an assessment of non-interviewable residents from 3/12/14 to 4/14/14 to determine any injury associated with possible abuse with no corrective action required.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225 Continued From page 33

incidents of abuse were immediately reported to the Administrator and appropriate State Agencies was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 04/03/14 and was determined to exist on 03/02/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/08/14 with the facility alleging removal of the Immediate Jeopardy on 04/07/14. The Immediate Jeopardy was verified to be removed on 04/07/14 as alleged with remaining non-compliance at a Scope and Severity of "D", while the facility develops and implements the Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure residents are free from abuse.

The findings include:

Review of the facility's policy: "OPS310 KY Abuse Prohibition", effective date 07/01/13, revealed anyone who witnessed an incident of abuse was to tell the abuser to stop immediately and report the abuse to the supervisor immediately. Policy review revealed the supervisor would then immediately report the alleged abuse to the Administrator and a written report was to be sent to the State Agency immediately, not to exceed twenty-four (24) hours. Further review of the policy revealed an investigation was to be initiated within twenty-four (24) hours of an allegation of abuse. Additionally, the policy revealed the facility was to protect residents from further "harm" during an investigation.

1. Review of the "Grievance/Concern Report" form revealed LPN #4 had completed it on

F 225

3. Director of Nurses, Administrator, Nurse Management, and Human Resources will have provided reeducation by 4/30/14 with the administrative, nursing, therapy, dietary, housekeeping, laundry, and maintenance staff regarding an effective system that ensures each resident

remains free of abuse:

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

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F 225	<p>Continued From page 34</p> <p>03/02/14. Review of the form revealed Resident #2 had reported to LPN #4 he/she tried to use the phone and LPN #1 "snatched" the phone away, hung it up, and told the resident he/she was not allowed to use it. Continued review of the form revealed Resident #2 also reported to LPN #4, LPN #1 told the resident if he/she continued to curse at her she would not give his/her pain medication. Further review revealed no documented evidence the incident was investigated as abuse or reported to State Agencies within twenty-four (24) hours after the alleged abuse.</p> <p>Review of LPN #1's personnel file revealed the employee was initially hired 12/11/12 and signed and dated she had received training on the facility's abuse policy on 12/11/12.</p> <p>Interview, on 04/03/14 at 2:30 PM, with Resident #2 revealed LPN #1 grabbed the phone from his/her ear, "slammed" it down on the receiver and said he/she had already made two (2) calls. Resident #2 revealed the LPN then said "wait until you want another pain pill" and indicated he/she had a lot of pain problems. Resident #2 reported going to LPN #4 and telling her what LPN #1 had done. The resident stated LPN #4 told him/her this was a grievance. According to Resident #2, the Director of Nursing Services (DNS) had talked to him/her the next day about the pain medication incident.</p> <p>Interview, on 04/02/14 at 2:39 PM, with Certified Nursing Assistant (CNA) #10 revealed when she worked on 03/02/14, she overheard LPN #1 tell Resident #2 he/she wouldn't get his/her medicine on time because the resident wasn't doing what he/she was supposed to do. The CNA indicated</p>	F 225	<ul style="list-style-type: none"> Center Abuse policy including need to protect the resident from potential risk at the time and during the investigation. Reporting requirements including immediate reporting to the Administrator and appropriate state agencies; Promise of confidentiality and no fear of retribution. Including stress management strategies for staff.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 35</p> <p>she told LPN #4 about what she had heard LPN #1 tell Resident #2 and LPN #4 said she would call the DNS. The CNA revealed she thought the incident was abuse; however, no one interviewed her about the incident. She indicated she felt the incident was not properly investigated.</p> <p>Interview, on 04/09/14 at 3:05 PM, with CNA #11 revealed she worked on 03/02/14 and witnessed Resident #2 trying to use the phone at the Unit 200 nurse's station and LPN #1 "grabbed" the phone from the resident's hand and "slammed" it down on the receiver. She stated LPN #1 told the resident he/she was not allowed to use the phone. According to CNA #11, LPN #1 told Resident #2 if he/she attempted to use the phone again she would not given the resident pain medication. She stated she considered LPN #1's actions as verbal or mental abuse and possible physical abuse because the nurse had "jerked" the phone from the resident's hand. CNA #11 indicated LPN #4, who was there, was going to take care of reporting the incident. Continued interview with the CNA revealed the facility did not contact her about the incident until last Friday, 04/04/14, and this was not the normal process when an allegation of abuse occurred. She indicated the facility's process was if an employee was involved they were suspended and the facility did an investigation at the time.</p> <p>Interview with LPN #4 on 04/02/14 at 11:36 AM, revealed sometime around shift change on 03/02/14, Resident #2 reported to her LPN #1 had "snatched" the phone from him/her and told the resident he/she could not use it anymore. According to LPN #4, Resident #2 told her he/she was upset when LPN #1 did that and he/she had cursed the nurse. LPN #1 then</p>	F 225	<ul style="list-style-type: none"> Employee competency assured using the Abuse Prevention post-test. Licensed nurses provided reeducation 3/14/14 by Director of Nurses regarding the need for licensed nurses to count off controlled medications and relinquish med cart keys with another nurse if leaving the center for lunch or other periods of time to ensure that medications are accessible to residents as needed. The Director of Nurses and Administrator were reeducated 3/12/14, 4/4/14, and 4/30/14 by the Manager of Clinical Operations regarding Abuse Policy and reporting requirements. 		

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

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F 225 Continued From page 36
informed the resident if he/she kept talking to her like that she would not give his/her pain medication. LPN #4 stated she felt Resident #2's report of how LPN #1 had treated him/her was an allegation of abuse and called the DNS who told her she would take care of it and did not tell her to send LPN #1 home. LPN #4 indicated she also documented the incident on a grievance form, attached a statement and gave one (1) to the Administrator, DNS and Social Services (SS).

Interview, on 04/01/14 at 3:52 PM, with LPN #1 revealed she asked Resident #2 once to use the phone at a later time because he/she had been on the phone "a lot" and the resident got upset, cursed, and walked away. LPN #1 stated there had been nothing said about pain medication and she unaware of any allegations related to pain medication.

Interview with Social Worker (SW) #1 on 04/03/14 at 1:57 PM and 2:53 PM and on 04/08/14 at 6:02 PM, revealed she had read the grievance form around the first week of March and was concerned because the content indicated the nurse had snatched the phone from Resident #2. SW #1 stated the grievance form had also stated the nurse had told Resident #2 if he/she kept cursing at her she would not give his/her pain medication. According to SW #1 she had discussed the grievance with the Administrator and DNS and what should be done next. However, she stated she could not recall what all was discussed or whether she had regarded the incident as abuse or only as a concern. SW #1 stated she interviewed Resident #2 on 04/03/14 regarding the alleged incident on 03/02/14 and after her interview with Resident #2, the incident sounded like abuse and the facility

F 225

- Employees upon hire and/or not working during this timeframe will have education/reeducation by administrative management to the center's abuse policy, reporting requirements, promise of confidentiality and no fear of retribution and will be repeated annually with all staff.
 - Facility does not use agency staff.
4. Administrator and Director of Nurse have assigned supervisors across the 3 shifts daily (includes Saturday and Sunday) to observe staff/resident interaction, and to determine that any allegations are reported immediately to the Administrator as of 4/4/14. Any concerns with staff interaction or allegations

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	Continued From page 37 should have performed a more thorough investigation when the incident first occurred as per the abuse policy. SW #1 stated the nurse was allowed to continue working after the incident and this was a concern regarding resident safety. She indicated the facility should have made sure residents were protected. Interview with the DNS on 04/02/14 at 12:30 PM and on 04/03/14 at 5:34 PM, revealed she had not been contacted by phone regarding the incident, but had the grievance form in her mailbox on 03/03/14. According to the DNS, initially she thought the incident was abuse and suspended the nurse after reading the statement. However, after interviewing Resident #2 twice, who denied the nurse had aggressively removed the phone from his/her hand and denied the nurse threatened him/her with not giving his/her pain medication, she did not think it was abuse after all. She revealed from the first day there was a breakdown in the facility's process, as other staff got the grievance and no one followed up to see if it was investigated. The DNS indicated she and the Administrator were responsible for taking the lead in investigations and she had suspended the nurse on 03/03/14 until she figured it out. She indicated she did not talk to the person who turned in the grievance form. She stated there had been a breakdown in her process for notifying the Administrator of the grievance. The DNS stated the facility did not follow the abuse investigation process and interview staff or residents. According to the DNS, if the facility did not fully investigate an allegation of abuse and the alleged perpetrator continued to work there was the potential for other abuse to have occurred. She further revealed it was important to ensure residents	F 225	identified will be called to the Administrator/DNS by the Shift Supervisor for review to determine any action to be taken including reporting to the state agency if indicated. Administrator, Director of Nursing, and Nurse Supervisors will interview 5 employees from all departments weekly x4 weeks and then monthly x3 months then as determined by the monthly Quality Assurance /Performance Improvement Committee to determine staff understanding of the abuse policy, reporting allegations to the Administrator immediately, and that allegations or statements are kept confidential with no fear of retribution for reporting. Concerns identified will be addressed upon discovery.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225 Continued From page 38
were safe and protected against abuse.

Interview with the Administrator on 04/03/14 at 6:23 PM and on 04/08/14 at 6:46 PM, revealed she should have been notified of the incident immediately. She stated she had not seen the grievance form until "around" 03/06/14 and after reading it she should have recognized the threat to withhold pain medication as an allegation of abuse. According to the Administrator, she should have removed the alleged perpetrator from resident care, reported to the State Agencies and done a thorough investigation of the allegation. The Administrator stated there was a breakdown in the recognition of the abuse allegation by the facility which led to the lack of an investigation and the failure to report.

2. Review of the facility's, "Self-Reported Incident Form", dated 03/14/14 revealed Resident #1's family had filed a grievance on 03/09/14, stating a nurse had spoken to the resident "unprofessionally". The Form stated Resident #1 requested his/her medication on night shift on the morning of 03/07/14 by using the call light multiple times and banging the call light on the table. LPN #6 went into the resident's room and told Resident #1 he/she was going to listen to what LPN #6 said and also told the resident he/she was bothering other residents by making so much noise. The nurse informed Resident #1 his/her behavior would not help get his/her pain medication any quicker. According to the Form, Interviews with staff revealed they had overheard the nurse yelling at the resident and telling him/her that hitting the bedside table would not get assistance any faster. LPN #6 also called the resident a "child" to the staff.

F 225 Administrator, Director of Nurses and Nurse Supervisors will interview 5 residents weekly x4 weeks and monthly x3 months to determine any issues with staff treatment or abuse and any issues with withholding of medication. Concerns identified will be addressed upon discovery.

Administrator and/or Social Services, or Shift Supervisors will review grievances, complaints and allegations daily (includes Saturday and Sunday) times 4 weeks then as determined by the monthly Quality Assurance /Performance Improvement Committee to determine that Abuse allegations are reported timely, resident is protected from further potential abuse as per the Abuse Policy and that investigations are thoroughly completed. Concerns identified will be addressed upon discovery.

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F 225	<p>Continued From page 39</p> <p>Review of LPN #6's personnel file revealed the employee was initially hired 04/20/10 and had signed and dated she had received training on the facility's abuse policy on 12/11/12.</p> <p>Interview, on 04/01/14 at 2:16 PM and on 04/02/14 at 4:15 PM and 5:14 PM with Resident #1, revealed a nurse on night shift had yelled at him/her and it took three (3) hours to get pain medication. Resident #1 indicated the nurse was upset because the resident was banging the call light and the nurse said he/she was acting like a kid. The resident further revealed when the nurse yelled it made him/her feel like a child and scared.</p> <p>Interview, on 04/02/14 at 8:55 AM, with CNA #7 revealed on the night of 03/06/14, Resident #1 requested pain medication, rang his/her call light multiple times, and banged the call light on the bedside table while the nurse was gone on break for over an hour. CNA #7 stated the nurse answered the resident's call light, was very loud and she could hear banging on the table and the nurse told Resident #1 he/she would not get the medication any quicker by banging on the table. According to CNA #7, she should have reported the incident immediately, but did not because she was scared it would get back to the nurse she had reported it. CNA #7 further revealed when she came back on Sunday, 03/09/14, two (2) days after the incident occurred, she talked to a nurse and weekend supervisor about the incident.</p> <p>Interview with CNA #3 on 04/02/14 at 8:55 AM and 04/09/14 at 6:58 PM, who also worked nightshift on 03/06/14 with CNA #7, revealed Resident #1 had used the call light approximately six (6) times for approximately an hour while the</p>	F 225	<p>The Human Resources personnel screen potential applicants for hire to determine if they have been found guilty of abusing, neglecting or mistreating residents. If found guilty, the applicant will not be eligible for hire.</p> <p>New hires will be trained on the abuse policy and procedures in orientation and then at least annually. Any employee who is alleged to abuse, neglect or mistreat residents will be reported by the</p>	