

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

PRINTED: 01/15/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 12/29/2014 |
| NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER | | STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018 | |
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F 000 INITIAL COMMENTS

F 000

AMENDED

An Abbreviated/Partial Extended Survey, investigating KY00022557, was initiated on 12/16/14 and concluded on 12/29/14. KY00022557 was substantiated with deficiencies cited. Immediate Jeopardy (IJ) was identified on 12/18/14, and was determined to exist on 11/25/14 at 42 CFR 483.13 Resident Rights, F-223, F-225 and F-226, 42 CFR 483.20, Resident Assessment, F-282 at a Scope and Severity of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of the Immediate Jeopardy on 12/18/14.

On 11/25/14, at approximately 3:30 PM to 4:00 PM, Certified Nursing Assistant (CNA) #1 was observed by two (2) other staff, CNA #2 and Nurse Aide in Training (NAT) #1, to intentionally spray Resident #1 in the face with hot and cold water during his/her shower. NAT #1 heard Resident #1 yell "stop, you're burning me". NAT #1 stated CNA #1 told Resident #1 if he/she would listen to her, she (CNA #1) "wouldn't have to do this". CNA #2 stated she heard Resident #1 tell CNA #1 to stop because he/she "didn't like that", and told CNA #1 the water was cold. Even though CNA #2 and NAT #1 observed CNA #1 intentionally spraying Resident #1 in the face with hot and cold water, neither staff member reported this to their immediate supervisor, as per the facility's policy. Interview and record review revealed CNA #1 continued to provide care for residents on the unit until 7:05 PM on 11/25/14. Interview with other facility staff revealed CNA #1 had a history of being "stern" with residents,

12/29/14
185447-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Adam Lwanowski Administrator 2/4/15
TITLE
(X5) DATE

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 225 Continued From page 63
F225, F226 and F282. Continued review revealed they discussed QA audits to be implemented, which included personnel files, review of facility investigations in the last thirty (30) days, skin assessments of residents, psychosocial assessments of residents, staff interviews/assessments, staff training, and staff implementation of residents' Comprehensive Care Plan and Kardex. The facility's abuse policy and procedure was also reviewed, and the reporting system reviewed.

Interview with the Administrator on 12/23/14 at approximately 2:40 PM, revealed the QA Committee met to discuss the deficiencies on 12/19/14 and 12/22/14. He reported they discussed the results of the survey and compliance through the audits to be implemented, such as in-servicing staff, reviewing personnel files, review of facility investigations in the last thirty (30) days, skin assessments of residents, psychosocial assessments of residents, staff interviews/assessments, staff training, and staff implementation of residents' Comprehensive Care Plan and Kardex. The Administrator indicated the facility's abuse policy and procedure was also reviewed.

12. Review of the inservice education from 12/19/14 through 12/22/14, revealed nursing staff and the IDT was provided education regarding residents' Comprehensive Care Plans and Kardex to ensure they were updated as necessary and staff implemented the residents' interventions. Continued review revealed the education was provided by the DON, ADON, Corporate RN, RN Managers and/or Team Lead Nurses.

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Interview, on 12/23/14 at 5:38 PM with RN #3, a Unit Manager, revealed she was part of the Nursing Leadership Team, and had assisted with providing the education to nursing staff and the IDT from 12/19/14 through 12/22/14.

Interview on 12/23/14 with: OT #1 at 4:38 PM; LPN #8 at 7:33 PM; RN #5 at 7:48 PM; and, on 12/24/14 with RN #4 at 8:25 AM revealed they all had received the education provided from 12/19/14 through 12/22/14. Per interviews, the education included information regarding residents' Comprehensive Care Plans, the Kardex and ensuring these were updated and ensuring staff implemented the interventions.

Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed the education had been provided as per the AOC.

13. Review of the audits of residents' care plans for behavior from 12/19/14 through 12/22/14 revealed they were performed by the RN/MDS/RAI Coordinator, MDS Licensed Nurses, the Corporate RN and/or Social Services Director. Review revealed the care plans were updated as necessary.

Review of the Inservice Attendance Sheet, dated 12/19/14 and ongoing, revealed staff signatures indicating they had received the Care Planning education.

Review of the facility's PI Worksheet audit for the Kardex, revealed staff were being observed and interviewed regarding the following: CNAs had their residents' Kardex on their person; and CNAs knew how to use the Kardex.

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| F 225 | Continued From page 65 Interview on 12/23/14 with: CNA #2 at 9:22 AM; CNA #14 on 12/23/14 at 3:51 PM; CNA #4 at 6:59 PM; CNA #16 at 7:12 PM; CNA #13 at 7:24 PM; and on 12/24/14 with: CNA #8 at 8:58 AM; CNA #12 at 9:05 AM; CNA #17 at 9:27 AM; CNA #15 at 4:05 PM revealed they all were recently inserviced on care plans related to the "Kardex". Per interview, they were familiar with the revision to their "Kardex" in which resident's behavior/mood was added. Continued interview revealed they continued to be questioned by management regarding whether they had their residents' Kardex on their person or not. Interview with the RN/MDS/RAI Coordinator on 12/24/14 at 9:31 AM, revealed she had trained staff on how to track and monitor resident's behavior and informed them of the additional behavior plan added to the Kardex. She revealed CNAs were informed to advise nursing staff if there were any changes in the resident's behavior and how to document the behavior in the facility's computerized charting system. Per interview, she looked through residents' care plans the first time, then the DON and Unit Managers checked the resident's care plans and Social Services looked through them as well to ensure appropriate interventions were in place. Interview with the Administrator and DON, on 12/24/14 at 10:23 AM, revealed the CNAs' Kardex was being reviewed daily and updated as needed. They further revealed that CNAs were providing input other staff might not be aware of regarding a resident's behavior. Per interview, rounds were being performed by them, the Unit Managers, Team Lead Nurses and/or Clinical Department Heads to interview and observe CNAs to ensure they had their residents' Kardex | F 225 | | | |

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| F 225 | Continued From page 66 on their person and were knowledgeable of the Kardex and the resident's interventions. According to the DON, the results of the observations and interviews were to be reported to her. The DON revealed staff was inserviced on residents' care plans and Kardex's and were informed the care plan directed each resident's plan of care. She stated CNAs were educated on residents' Behavior/Mood being added to the Kardex and the interventions on how to deal with the resident's behaviors. She revealed the Kardex's were to be reviewed and revised as necessary, and printed out for the CNAs. | F 225 | F226 1. Resident #1 was assessed by the Director of Nursing on 11/26/14 about occurrence in shower. RN performed full skin assessment on 11/26/14 with no findings related to the occurrence of 11/25/14. Licensed Social Worker on 11/26/14 and 12/18/14 assessed and has provided support to resident who has voiced no concerns with the staff/shower incident that occurred and has had no concerns of any other staff member abuse. MDS nurse completed comprehensive assessment of resident on 12/19/14 and noted no concerns, nor any difficulties with late effects of occurrence of 11/25/14. Comprehensive Care Plans and Kardex (CNA Care Plan); verified on 12/20/14 by DON, reflect individualized approaches to manage behaviors. Resident resides at facility, visited often by wife, assessed by licensed nursing staff and social worker to be safe and secure. Alleged Team Member was terminated on 11/28/14 after investigation. | | |
| F 226 SS=J | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure facility staff implemented the facility's abuse policy and procedures for one (1) of five (5) sampled residents (Resident #1). In addition, the facility failed to develop a policy consistent with Federal and State Guidelines regarding immediate notification of the Administrator. Resident #1, on 11/25/14, was escorted to the shower room for his/her shower somewhere between 3:30 PM and 4:00 PM. Three (3) staff | F 226 | 2. On 12/19/14, each cognitively intact resident with a BIMS >= 8 was interviewed by the Social Worker, Registered Dietician, | | |

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F 226 | Continued From page 67

was present in the shower room with Resident #1, who included Certified Nursing Assistant (CNA) #1, Nurse Aide in Training (NAT) #1 and CNA #2. CNA #2 and NAT #1 witnessed CNA #1 intentionally spray Resident #1 in the face with hot and cold water. However, CNA #2 and NAT #1 did not report the alleged abuse until approximately 6:00 PM which allowed CNA #1 to continue to provide care for Resident #1 and other residents on the unit. At approximately 6:00 PM, NAT #1 informed CNA #4 of the alleged abuse he had witnessed involving Resident #1 in the shower room. CNA #4 reported the alleged abuse to Licensed Practical Nurse (LPN) #1, who reported the incident/alleged abuse to the Director of Nursing (DON). The DON initiated an investigation and removed CNA #1 from resident care after she became aware of the alleged abuse. CNA #1 clocked out from work at 7:05 PM. (Refer to F223 and F225)

The facility's failure to ensure an effective system was in place to ensure facility staff implemented the facility's abuse policy and procedures and to develop a policy consistent with Federal and State Guidelines regarding immediate notification of the Administrator was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/18/14, and determined to exist on 11/25/14. The facility was notified of the Immediate Jeopardy on 12/18/14.

The facility provided an acceptable Credible Allegation of Compliance (AOC) on 12/23/14, with the facility alleging removal of the Immediate Jeopardy on 12/23/14. The Immediate Jeopardy was verified to be removed on 12/23/14, as alleged, with remaining non-compliance in the

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Activity Director and/or Director of Rehabilitation to observation and interview for resident concerns of any potential abuse, neglect or misappropriation. Any allegation/concern was immediately followed up with by the Administrator; investigations completed as well as notifications, if indicated, were made by the Administrator.

On 12/18-19/14, Licensed nursing staff conducted head to toe assessments of each cognitively impaired resident (BIMS < 8 or non-interviewable) for any new/unusual bruises, skin tears etc., or other signs of potential abuse. There were no findings that would trigger an allegation of abuse. Results were reviewed by the Director of Nursing and Administrator.

Findings were reviewed with Administrator on 12/19/14 and will be reported to the 12/22/14 QA meeting by the Business Office Coordinator.

On 12/19/14, the Facility Administrator, Corporate Compliance Officer and Risk Manager reviewed each file of resident allegation of abuse/self-report of potential abuse in the past 30 days to assure completeness and

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F 226 Continued From page 68

area of 42 CFR 483.13, Resident Behavior and Facility Practice, F-226 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the Abuse Policies for implementation to ensure residents were free from abuse.

The findings include:

Review of the facility's policy titled, "Abuse/Neglect/Misappropriation of Property", revised October 2014, revealed "abuse" was defined to include the wilful infliction of injury, unreasonable confinement, intimidation, or corporal punishment with resulting physical harm, pain, or mental anguish. Continued review of the facility's policy revealed when an incident or occurrence was identified as abuse, neglect or misappropriation an investigation would immediately follow. Review of the Policy, under the "Identification" section for "Staff Reporting Requirements", revealed when staff suspected abuse had occurred against a resident of the facility, they must report the incident to their immediate supervisor and, an investigation would immediately be initiated. However, Policy review revealed no documented evidence of the timeframe in which staff was to report suspected abuse incidents to their immediate supervisor. Additionally, the "Staff Reporting Requirements" of the Policy's "Identification section revealed notification of the DON (Director of Nursing)/Administrator would "occur ASAP (as soon as possible) but no later than two (2) hours if a serious injury" was suspected. However, the "Reporting/Response" section of the Policy revealed "alleged violations were to be reported

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thoroughness of investigation. On 12/20/14 any concerns/gaps identified were followed up accordingly by the Administrator. On 12/21/14, the Facility Administrator, Corporate Compliance Officer and Risk Manager reviewed additional investigation files generated by whole house observation and interviews completed 12/19-20/14. This included, but was not limited to, immediate removal of any alleged or perpetrating staff from any care area, immediate reporting to administrator, interview of resident and staff, assessment of alleged victim, review of investigation action meeting policy and federal requirements.

On 12/19/14 Administrator/COO, DON, Risk Manager and Corporate Compliance Officer reviewed Abuse/neglect/misappropriation of property policy in place at time of the survey, addressing concerns identified by surveyors, comparing federal regulations and interpretive guidelines to the contents of the facility policy. Findings addressed, in revision of policy on 12/19/14.

On 12/19/14 all personnel files were audited by the Business Officer Coordinator and Medical Records Director for completion of pre-hire components used by the

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| F 226 | Continued From page 69 immediately to the Administrator. Review of the facility's Self-Reported Initial Report Incident form, dated 11/25/14, revealed a staff member reported CNA #1 sprayed Resident #1 in the face with water while giving him/her a shower. Review of the facility's, "5 Day Follow-up/Final Report" form dated 11/28/14 and investigation documentation, revealed two (2) staff witnessed the alleged abuse of Resident #1, and "had the same general statement" that CNA #1 "intentionally sprayed water in the resident's face". Review of the facility's investigation of the incident revealed Resident #1 reported a female aide took the shower head and sprayed him/her directly in the face with water. The resident asked the female aide to stop but the aide laughed at the resident and continued to spray him/her. Review of NAT #1's written statement dated 11/25/14 at 7:15 PM, revealed on 11/25/14 at 4:00 PM, Resident #1 was being given a shower and was sprayed in the face with hot water by CNA #1, and the resident screamed "stop spraying my face, you are burning me". Review of CNA #2's written statement dated 11/25/14 at 6:15 PM, revealed CNA #1 "intentionally" sprayed Resident #1 in the face with water at approximately 4:30 PM. However, further review of the "5 Day Follow-up/Final Report" form and investigation documentation revealed no documented evidence the Administrator was immediately notified of the alleged abuse, per the facility's policy. Interview, on 12/17/14 at 1:09 PM, with NAT #1 revealed he did not tell anyone what he had witnessed in the shower room until around 5:30 | F 226 | facility as part of screening and prevention of abuse. Files were 100% compliant. 3. Facility Abuse/Neglect/Misappropriation of Property policy was revised on 12/19/14 by COO, VP Risk Management, and Corporate Compliance Officer. (See Attached as Exhibit A) Alleged Team Member was terminated on 11/28/14 On 12/19/14 the Corporate Compliance Officer in-serviced the Administrator, DON, ADON, Unit Managers and each Department head on the results of the survey, our root-cause analysis of the deficiencies, the newly revised abuse policy and procedure. Additionally, on 12/19/14 the Corporate Compliance Officer in-serviced each Department Head, in a Train the Trainer fashion, on the Team Member Education which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) to ensure each staff member is in-serviced by 12/22/14. This updated policy was reviewed and referred to in the all staff Team Member Education in-service, delivered from 12/19-22/14. On 12/19/14, the policy, | |
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PM. Even though the facility's policy stated when staff suspected abuse had occurred against a resident of the facility, they must report the incident to their immediate supervisor. Further interview revealed he observed CNA #1 before being a "bit aggressive" with residents and a little "rough" and he had heard her yell at residents. However, even though he thought these behaviors could be abusive he had never reported this information to his immediate supervisor, as per facility policy.

In regards to the incident on 11/25/14, NAT #1 revealed he had not been aware of the Policy requirements regarding reporting to his immediate supervisor, the DON or Administrator, as the facility had not provided adequate training on the Policy. He was an aide in training and did not know if what he had observed was abuse or not. He completed orientation via the computer and document review revealed he acknowledged he had reviewed the abuse policy and was responsible for its content on 11/11/14. Per interview, NAT #1 stated he now was aware he should have reported the alleged abuse to his supervisor immediately so the DON and Administrator could have been notified and thereby, ensured Resident #1 and other residents were safe.

Interview, on 12/16/14 at 5:25 PM and on 12/17/14 at approximately 3:30 PM, with CNA #2 revealed she was aware of the facility's abuse policy. She stated if she witnessed abuse she would report it to her "supervisor or someone in charge". However, she indicated she was "non-confrontational", and even though she thought the incident was abusive she had not reported it to RN #1, her immediate supervisor,

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besides being directly taught to the staff, was placed in each area that team members typically congregate, take breaks and eat lunch breaks. Evidence of learning measured via written post-test; 100% accuracy required

On 12/19/2014-12/22/14 all staff (licensed nurses, certified nurse aides, licensed therapy staff, social service, activity, dietary, housekeeping, business office and maintenance) was provided in-service education by the Corporate Compliance Officer, Administrator, DON or Trained Trainer Department Head which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and reporting concerns immediately. Evidence of learning measured via written post-test; 100% accuracy required.

On 12/21/14 the Corporate Risk Manager and Corporate Compliance Officer each provided additional education to the Administrator, Director of Nursing, and Nursing Leadership Team on (1) review of federal regulations and interpretive guidelines of F223; F225, F226; (2) additional review of revision of Facility Policy on Abuse/Neglect/Missappriation of

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| F 226 | <p>Continued From page 71</p> <p>as per the facility's policy. Continued interview revealed she realized later on she should have reported the incident as possible abuse, but she did not see a need to report it at the time as NAT #1 had already reported it.</p> <p>Interview, on 12/17/14 at 2:35 PM, with CNA #1 revealed she was not aware of a concern with her care of Resident #1 until the DON approached her later on after dinner. CNA #1 stated the DON asked her to write a statement concerning the alleged abuse of Resident #1, and then told her she was suspended. CNA #1 reported she was informed by the Administrator she was terminated, on 11/28/14, due to statements provided to them from NAT #1.</p> <p>Interview, on 12/16/14 at 5:43 PM, with LPN #1 revealed on 11/25/14, CNA #4 reported what NAT #1 had told her regarding the shower room incident involving Resident #1. LPN #1 stated she immediately reported the incident to the DON, and the DON asked her if CNA #1 was removed from resident care. She stated she told the DON this had not occurred.</p> <p>Interview with Registered Nurse (RN) #1, on 12/16/14 at 4:27 PM, revealed she was the nurse supervising the CNAs on Resident #1's hall which included CNA #1 and CNA #2 on 11/25/14. However, she stated neither CNA #2 nor NAT #1 reported the incident/alleged abuse to her on 11/25/14, after it occurred. Continued interview revealed she was not made aware of the alleged abuse of Resident #1 by CNA #1, until the next day, 11/26/14. According to RN #1, her expectation would have been for CNA #2, who was under her supervision, to have reported the abuse to her immediately. RN #1 indicated NAT</p> | F 226 | <p>Property; (3) root cause analysis of survey findings related to systematic response to allegations. Evidence of learning measured via meaningful Q&A and discussion of case examples and a repeat verbalization of understanding of definitions and the facility system.</p> <p>No agency use at the facility.</p> <p>Any staff member who has not been at work or on leave or on vacation will complete all education and training prior to working their shift. No staff member will work without first being in-serviced. All newly hired staff members will be provided in-service education on abuse prevention, identification and reporting during their orientation prior to working in the facility through the interactive computer program with post-test and review of Abuse policy with signed verification. The Business Office Coordinator will track completion.</p> <p>The Business Office Coordinator and Administrator will review each new hire personnel file to assure verifications and background checks are completed prior to beginning work.</p> <p>Annual mandatory in-service of Abuse, including but not limited to prevention, will continue to be</p> | |

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| F 226 | Continued From page 72 #1 should have reported the alleged abuse to her or his direct supervisor immediately. Interview with the DON on 12/18/14 at 1:00 PM, revealed LPN #1 told her NAT #1 informed CNA #4 what he had witnessed in the shower room involving Resident #1 and CNA #1. She revealed she removed CNA #1 from resident care, questioned her regarding the shower incident, had her write a statement and then informed CNA #1 to leave the facility. Per interview, after ensuring CNA #1 had left, she talked to NAT #1 and CNA #2 and asked them to provide their written statements regarding the alleged abuse. She stated her expectation was for staff to report incidents/alleged abuse within "a couple of hours" if harm had occurred to a resident. However, the DON then stated the facility's policy was for staff to report any incidents of alleged abuse immediately, and this was her expectation of staff. However, review of the current facility policy revealed notification would "occur ASAP (as soon as possible) but no later than two (2) hours if a serious injury" was suspected. According to the DON, CNA #2 stayed with Resident #1 to ensure his/her safety after the shower room incident. However, the DON indicated she did not have an answer as to how the facility had ensured other residents were protected if staff hadn't reported the alleged abuse when it occurred. Interview with the Administrator, on 12/18/14 at 2:06 PM, revealed he was notified by the DON on 11/25/14 "between 6:00 PM and 7:00 PM" of the alleged abuse of Resident #1 by CNA #1. He stated he followed-up with NAT #1 and CNA #2, and they both felt CNA #1 intentionally sprayed Resident #1 in the face with water. He revealed | F 226 | monitored by the Business Office Coordinator; additionally as indicated by concerns or observations, impromptu in-services for staff will be held as decided by the Administrator, DON and/or Ombudsman. 4. A Quality Assurance meeting was held on 12/19/14 with the Medial Director, Director of Nursing, Administrator and other members of the Quality Assurance Committee. The findings of the state survey as well as deficiencies, including scope and severity, were discussed. Action plans to address each deficiency as well as the overall system were developed and approved by the QA Committee. On 12/22/14 a second full Quality Assurance meeting was held to review the action plans to remove immediate jeopardy. Findings of all observations and interviews, compliance with in-servicing and results of monitoring were analyzed and discussed. Findings will be reported by the DON, Administrator or Social Services Director and followed by each with Committee recommendations. QA Committee recommends Allegation of Compliance – removal of immediate jeopardy date by 12/23/14. The QA team consists of the | | |

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NAT #1's waiting to report the alleged abuse was acceptable, because given the "context of the situation" the NAT was not sure whether CNA #1 had intentionally sprayed Resident #1 in the face. The Administrator stated once NAT #1 thought the incident was abuse, he reported it to someone. He stated however, the facility's expectation was if an incident was viewed by staff as abuse, it should be reported as soon as possible. Continued interview revealed if NAT #1 and CNA #2 thought the incident was alleged abuse at the time it occurred, they should have reported it, as per facility policy. He stated once NAT #1 and CNA #2 felt the incident was potentially abuse they had reported it. According to the Administrator, the facility policy's intent was for staff to report possible abuse immediately. He stated staff should "report as soon as reasonably possible". Further interview with the Administrator revealed spraying a resident intentionally in the face with water could be abuse, "if that's what's perceived" by the individual observing it. Per the Administrator, his staff was educated on abuse, knew "right from wrong", and he felt his staff had followed the facility's policy.

Additional review of the facility's abuse policy at the time of interview with the Administrator, revealed when staff suspected abuse of a resident had occurred they must report the incident to their immediate supervisor; however, the Policy did not indicate the timeframe in which staff should report to their immediate supervisor.

Continued interview with the Administrator on 12/18/14 at 2:06 PM, and review of the facility's abuse policy with him at that time, revealed alleged abuse allegations "should get to the DON

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Medical Director, DON, Administrator and Departments Heads, which meets weekly. All monitoring/auditing of verifying timely reporting of allegation/grievance/report results are reviewed by the QA Team with appropriate follow-up required as needed. QA meetings were held on the following dates: 12/19/14, 12/22/14, 12/23/14, 12/29/14, 1/5/15, 1/12/15, and 1/19/15. QA Committee meetings will continue weekly for 8 weeks and then the frequency will be determined by QA Committee with a minimum of quarterly.

Audits began on 12/20/14 with observation and interview of staff members, while staff are performing their respective direct care job duties/responsibilities, by Administrator, DON, RN Nurse Managers, and other Department Heads to ensure deficient practice does not occur. Observation and interview designed to detect if staff members are knowledgeable about prevention, reporting, investigation of abuse and know how to locate and review the revised abuse policy. Facility will perform interviews of at least 20 staff members weekly, across different shifts and on weekends, until Substantial Compliance is obtained. After Substantial Compliance is

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as soon as possible". However, the Administrator also indicated it was the intent of the facility's abuse policy for staff to report immediately, and not wait two (2) hours if a serious injury had occurred. He stated the two (2) hour timeframe was meant for management staff to follow when reporting to the State Survey Agency. Per interview, the Administrator revealed he understood how the Policy could have been misinterpreted.

The facility provided an acceptable Credible Allegation of Compliance (AOC) on 12/23/14 which alleged removal of the IJ effective 12/23/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was assessed by the DON on 11/26/14, regarding the occurrence in the shower. An RN performed a full skin assessment of Resident #1 on 11/26/14 with no findings related to the occurrence of 11/25/14. A Social Worker (SW) assessed Resident #1 on 11/26/14 and on 12/18/14 and provided support to the resident who voiced no concerns with the staff/shower incident and had no concerns of any other staff member abuse. A MDS Nurse completed a comprehensive assessment of Resident #1 on 12/19/14 and noted no concerns, nor any difficulties with late effects of the occurrence of 11/25/14. Resident #1's Comprehensive Care Plans and Kardex (CNA Care Plan), were verified on 12/20/14 by the DON to reflect individualized approaches to manage his/her behaviors.
2. On 12/19/14, each cognitively intact resident with a Brief Interview of Mental Status (BIMS) greater than or equal to eight (8) was observed and interviewed by the SW, Registered Dietician

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obtained, the QA team will determine the frequency of the staff interviews. (See Attached as Exhibit B) Findings of each observation and interview developed for this POC are evidence of the operationalization of the facility's policy on abuse/neglect/misappropriation of property. All findings of observations and interviews will be reviewed by the QA Committee to ensure team members of the facility understand, implement and operationalize the policy.

Each allegation of abuse will be reported immediately by the staff to the Director of Nursing or the Administrator. If the DON or administrator is not in the facility, they will contact the DON or Administrator via phone, which these numbers are posted in multiple different locations (the time clocks and nursing stations) for thorough/timely investigation and reporting. The Administrator is notified immediately of each allegation, across all shifts and weekends.

Corporate Compliance Officer and/or Risk Manager will perform a weekly observation and review of all facility investigations. This includes, but is not limited to, immediate removal of any alleged

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(RD), Activity Director and/or Director of Rehabilitation for resident concerns of any potential abuse, neglect or misappropriation. The findings of the interviews and observations were reported to the Administrator on 12/19/14. Any allegation/concern was immediately followed up on by the Administrator, with investigations completed, and notifications made, if indicated, by the Administrator. The findings were to be reported at the 12/22/14 Quality Assurance (QA) Committee meeting by the Business Office Coordinator. The SW was to continue to perform interviewable resident abuse observations and interviews weekly and report the findings to the QA team.

3. On 12/18/14 through 12/19/14, licensed nursing staff conducted head to toe assessments of each cognitively impaired resident, who had a BIMS less than eight (8) or was non-interviewable, for any new or unusual bruises, skin tears etc., or other signs of potential abuse. There were no findings that would trigger an allegation of abuse. The results of the head to toe assessments were reviewed by the DON and Administrator, and the findings reported at the 12/22/14 QA meeting by the DON. The Nursing Management Team which included the DON, ADON, Unit Managers and Team Leads would perform head to toe assessments of each cognitively impaired resident weekly for any new/unusual bruises, skin tears etc., or other signs of potential abuse, with no findings that required action at the time.

4. On 12/18/14 the facility's electronic charting system was modified by the Corporate Nurse to list/show interventions for residents' behaviors on the Kardex (nurse aide care plan). Each

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or perpetrating staff from the facility, immediate reporting to administrator, interview of resident and staff, assessment of alleged victim, root cause analysis, conclusion, and review of investigation action meeting policy and federal requirements, results provided to QA Committee

The Interdisciplinary Team consists of Administrator, DON, Social Worker, Licensed Dietician, Chef, Maintenance Director, Activities Director, Medical Records Director, Business Office Coordinator, Housekeeping Supervisor, RN Unit Managers, and other Department Heads. The Interdisciplinary Team has daily "Stand Up" meetings on Monday - Friday lead by the Administrator and DON. These will be on-going. Any incident/grievances/requests, etc. are addressed as needed and reported to the IDT the following meeting day. If any incident/grievance occurs on the weekend, it will be discussed in the Monday morning meeting. Again, the Administrator is notified immediately of each allegation, across all shifts and including weekends. The corporate compliance officer or the chief operating officer is notified by the administrator of any allegations. The CCO or the COO will monitor

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residents' Kardex was updated automatically. By 12/19/14 the Registered Nurse (RN)/MDS/Resident Assessment Instrument (RAI) Coordinator reviewed all residents care plans to ensure Behavior Comprehensive Care Plans were in place for each resident assessed to require one.

5. On 12/19/14, the Administrator, Corporate Compliance Officer (CCO) and Corporate Risk Manager (CRM) reviewed each file of resident allegations of abuse or facility self reports of potential abuse in the past thirty (30) days to assure completeness and thoroughness of the investigation. If there were any concerns/gaps identified, they were followed up accordingly by the Administrator. On 12/21/14, the Administrator, CCO and CRM reviewed additional investigation files which were generated by the facility's observations and interviews completed on 12/19/14 through 12/20/14. This included, but was not limited to: immediate removal of any alleged or perpetrating staff from any care area; immediate reporting to the Administrator; interview of resident and staff; assessment of the alleged victim; and review of the investigation action ensuring it met the policy and federal requirements. The Administrator took action, if any required. The alleged perpetrator, CNA #1 was terminated on 11/28/14 after the completion of the facility's investigation.

6. On 12/19/14 all personnel files were audited by the Business Officer Coordinator and Medical Records Director for completion of pre-hire components used by the facility as part of screening and prevention of abuse. The files were found to be one hundred percent (100%) compliant, with evidence of: current License

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the process of the investigation daily until the investigation is finalized. The CCO or the COO will ensure audit the investigation and allegations to ensure substantial compliance.

The QA team consists of the Medical Director, DON, Administrator and Departments Heads, which meets weekly. All monitoring/auditing of verifying timely reporting of allegation/grievance/report results are reviewed by the QA Team with appropriate follow-up required as needed. QA meetings were held on the following dates: 12/19/14, 12/22/14, 12/23/14, 12/29/14, 1/5/15, 1/12/15, and 1/19/15. QA Committee meetings will continue weekly for 8 weeks and then the frequency will be determined by QA Committee with a minimum of quarterly.

All monitoring findings will be reviewed at Quality Assurance Meetings that will take place weekly, until facility is in Substantial Compliance, when that occurs, the QA Committee will decide on frequency of meetings with a minimum of Quarterly, in order to keep facility in Substantial Compliance. QA team consists of Medical Director, DON, Administrator and Departments

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verification; Abuse Registry Check Registration; Criminal Background Check; and Kentucky Caregiver Misconduct Registry check. The findings of the audit were reported to the Administrator on 12/19/14 and were to be reported to the QA Committee on 12/22/14, by the Business Office Coordinator. The Business Office Coordinator and Administrator would review each new hire personnel file to assure verifications and background checks were completed prior to beginning work.

7. The facility's Abuse/Neglect/Misappropriation of Property Policy was reviewed on 12/19/14, which was in place at the time of the survey, addressing concerns identified by surveyors, by comparing it to federal regulations and interpretive guidelines and the contents of the facility's policy. The facility's Abuse/Neglect/Misappropriation of Property Policy was revised on 12/19/14 by the Chief Operating Officer (COO), Vice President (VP) of Risk Management, and CCO.

8. On 12/19/14 the CCO inserviced the Administrator, DON, ADON, Unit Managers and each Department Head on the results of the survey, the facility's root-cause analysis of the deficiencies and the newly revised abuse policy and procedure. Additionally, on 12/19/14 the CCO inserviced each Department Head, in a "Train the Trainer" fashion, on the "Team Member" education which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and the revised policy.

On 12/21/14 the CRM and CCO each provided additional education to the Administrator, DON,

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Heads.

5. Date of Compliance: The facility has continued to execute all audits, preventative measures, policy revisions and monitoring of performance developed via the AOC and POC process. Analysis of the whole, via QA meetings, indicates our system is working and substantial compliance alleged 1/12/15.

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| F 226 | <p>Continued From page 78</p> <p>and Nursing Leadership Team on: review of federal regulations and interpretive guidelines for F223, F225, F226; additional review of the revision of the facility's policy on Abuse/Neglect/Misappropriation of Property; and root cause analysis of the survey findings related to systematic response to allegations. Evidence of the learning was measured via meaningful Question and Answer (Q & A) and discussion of cause examples and a repeat verbalization of understanding of definitions and the facility's system.</p> <p>9. On 12/19/14 through 12/22/14 all staff including licensed Nurses, CNAs, licensed Therapists, Social Services, Activity, Dietary, Housekeeping, Business Office and Maintenance was provided inservice education, "Team Member" Education, by the CCO, Administrator, DON or Trained Department Head which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and reporting concerns immediately. The updated abuse policy was reviewed and referred to in all staff "Team Member" education in-services, performed from 12/19/14 through 12/22/14. Evidence of the staff member's learning was measured via a written post-test, with a 100% accuracy required. Any staff member who had not been at work, or was on leave or vacation would complete all education and training prior to working their next shift. No staff member would work without first being inserviced. All newly hired staff members would be provided inservice education on abuse prevention, identification and reporting during their orientation prior to working in the facility through the Interactive Computer Program with a post-test and review of the abuse policy signed</p> | F 226 | | |
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| F 226 | <p>Continued From page 79 for verification. The Business Office Coordinator would track completion.</p> <p>Annual mandatory inservice of abuse, including but not limited to prevention, would continue to be monitored by the Business Office Coordinator; additionally, as indicated by concerns or observations, impromptu inservices for staff would be held as decided by the Administrator, DON, and/or Ombudsman.</p> <p>Also, besides being directly taught to staff, the revised policy was placed in areas staff/team members typically congregate, take breaks and eat lunch.</p> <p>10. Beginning on 12/20/14, a random observation and interview of staff members was begun by the Administrator, Corporate support staff and Department Heads. The observations and interviews were designed to detect if staff members were knowledgeable about prevention, reporting, investigation of abuse and how to locate and review the revised abuse policy. The facility was to perform interviews of at least twenty (20) staff members weekly until substantial compliance was obtained to ensure each allegation of abuse would be reported immediately by the staff to the DON or Administrator. If the DON or Administrator was not in the facility, staff would contact the DON or Administrator via phone for thorough/timely investigation and reporting. The Administrator would be notified immediately of any allegations. After substantial compliance was obtained, the QA team would determine the frequency of the staff interviews.</p> <p>The findings of each observation and interview</p> | F 226 | | |
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developed for this Allegation of Compliance (AOC) were evidence of the operationalization of the facility's policy on abuse/neglect/misappropriation of property. All findings of observations and interviews would be reviewed by the QA Committee to ensure team members understood, implemented and operationalized the policy.

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11. The QA team consists of the Medical Director, DON, Administrator and Department Heads. A QA meeting was held on 12/19/14 with the Medical Director, DON, Administrator and other members of the QA Committee. The findings of the State Survey Agency's findings, as well as, deficiencies, including the Scope and Severity, were discussed in the meeting. Action plans to address each deficiency, as well as, the overall system were developed and approved by the QA Committee. On 12/22/14, a second full QA Committee meeting was held to review the action plans to remove the Immediate Jeopardy. Findings of all observations and interviews, compliance with inservicing and results of monitoring were analyzed and discussed. The findings would be reported by the DON, Administrator or Social Service Director and followed by each with Committee recommendations. QA meetings would take place weekly, until the facility was in substantial compliance, and when that occurred the QA Committee would decide on the frequency of meetings with a minimum of quarterly, in order to keep the facility in substantial compliance.

12. From 12/19/14 through 12/22/14, the DON, ADON, Corporate RN, RN Managers and/or Team Lead Nurses provided additional inservice/education to the Nursing staff and

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Interdisciplinary Team (IDT) on the Comprehensive Care Plan and communication of interventions to the Kardex/Nurse Aide Care Plan for implementation. Included in this training was the importance of accessing the Kardex, communicating changes needed to maintain an accurate and updated Plan of Care, including the Kardex, for each of the facility's residents.

13. On 12/19/14 through 12/22/14, the RN/MDS/RAI Coordinator, MDS Licensed Nurses, the Corporate RN, and/or Social Service Director reviewed each residents' care plan for behavior to assure interventions were appropriate and flowed automatically to the Kardex (nurse aide care plan) based on feedback and assessment by the direct care staff which included the CNAs, licensed Nurses, Unit Managers and Social Service Director. The care plans were updated as indicated. The findings were reviewed with the DON and Administrator on 12/22/14 and would be reported to the QA Committee on 12/22/14 by the DON.

The Kardex's were to be reviewed and updated daily by the Charge Nurses, Unit Managers, MDS Nurses, Team Lead Nurses and/or Therapists to assure they were current and provided appropriate interventions for each resident. The Kardex was to be printed off each day by the Charge Nurse and a copy of the Kardex given to the CNAs. The Kardex copy and verbal report from the nurse was given to each CNA to ensure the direct care staff was aware of the interventions in place for each of the facility's residents. If the Kardex was not current, licensed staff would update it and assure the CNA had the updated copy. CNAs were made aware they were to communicate verbally or via the Kardex

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to the nurses any concerns or need for further assessment or update of the resident's care plan/Kardex. Resident #1's Kardex was reviewed by the Charge Nurse for changes of the Plan of Care for the resident.

Observation and interview rounds will be completed by the Administrator, DON, Unit Manager, Team Lead Nurses and/or licensed Clinical Department Heads to ensure each direct care staff person had the Kardex copy on their person and was able to use it. Results of the observations and interviews would be reported to the DON. The DON would report the findings at the 12/22/14 QA meeting.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Review of Resident #1's skin assessment, dated 11/26/14, revealed no open areas or bruising noted. Review of the Social Services Note, dated 12/19/14 revealed a late entry from the Social Worker to address her interview with the resident on 11/26/14 to discuss the incident/alleged abuse on 11/25/14. Continued review of the Social Service Notes, dated 12/18/14 and 12/19/14, revealed the Social Service Director followed up with the resident to assess Resident #1's psychosocial well-being. Review of Resident #1's Comprehensive Assessment, dated 12/19/14, revealed the resident was assessed by Licensed Practical Nurse (LPN) #7/MDS Nurse with no concerns identified. Review of Resident #1's Kardex revealed a Behavior/Mood care plan was added to the Kardex. Review of Resident #1's Comprehensive Care Plan revealed the resident's care plan was revised on 12/19/14 for staff to

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| F 226 | Continued From page 83 analyze key times, places, circumstances, triggers, and what de-escalated his/her behavior and document the information, as the resident was noted to have increased anxiety with showers and when his/her spouse had left for the day. Interview with the DON, on 12/24/14 at 10:23 AM, revealed Resident #1 was assessed "that night" (11/25/14) and Social Services continued to follow up with the resident. She stated Resident #1 resident was assessed again on 12/18/14 and his/her care plan was updated/revised. She reported she reviewed the resident's updated/revised care plan and verified it was complete regarding the changes that needed to be reflected on his/her care plan. She further stated the CNAs' Kardex had been updated with the changes. Continued interview with the DON revealed the SSD also assessed the resident on 12/18/14 and had been following up with the resident by reviewing his/her care plan. Interview with the SSD, on 12/24/14 at 10:05 AM, revealed she talked to Resident #1 on 12/18/14, and had followed up with him/her since. Continued interview revealed Resident #1's care plan was updated related to his/her behavior and bathing. 2. Review of the facility's Resident Rights/Abuse Prevention/Comprehensive Care Plans Audit Worksheets, dated 12/18/14 and 12/19/14, revealed residents with a BIMS score of eight (8) or higher were interviewed by the Director of Social Service, RD, Activity Director and/or Director of Rehabilitation. Two (2) residents, Unsampled Resident A and Unsampled Resident B, who also resided on Resident #1's unit | F 226 | | |

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expressed concerns on 12/21/14, regarding staff, these concerns were not abuse related. The residents' concerns were related to staff not being able to work together to provide care, and staff not taking the time to talk to them. Continued review of the audit revealed the Administrator followed up with the two (2) residents on 12/22/14.

Interview on 12/24/14, with Unsampld Resident A at 9:30 AM and Unsampld Resident B at 9:40 AM, revealed they were questioned by staff regarding any concerns they had of abuse by staff; however, neither resident expressed concerns regarding abuse.

Interview with the Social Services Director, on 12/24/14 at 10:05 AM, revealed she interviewed all of the interviewable residents with a BIMS score of eight (8) or higher on all the facility's units. She reported there were no concerns of abuse given. The Social Services Director stated the Administrator followed up on some residents' concerns which were not related to abuse. Per interview, the interviewable residents would continue to be interviewed regarding any abuse concerns, and observations performed at the time of interview to ensure the residents had no signs or symptoms of abuse.

Interview, on 12/23/14 at 3:19 PM, with the Business Office Coordinator revealed the findings of the audits were reported to the QA Committee on 12/22/14.

Interview, on 12/24/14 at 10:23 AM, with the Administrator revealed the findings of the interviews and observations were reported to him on 12/19/14, and continued to be reported.

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| F 226 | Continued From page 85 3. Review of the skin assessments, dated 12/19/14, of residents identified as having a BIMS of seven (7) or less and non-interviewable residents revealed they were assessed by nursing staff who included RN #4, LPN #8, the ADON and LPN #7. Review of the skin assessments revealed no new or unusual bruising, no concerns were noted. Interview with LPN #8, on 12/23/14 at 7:33 PM, revealed she did skin assessments for residents who had a BIMS of seven (7) or less, or who were non-interviewable. She stated she assessed the residents on 12/19/14, and no concerns were observed or noted. Interview with the DON on 12/24/14 at 10:23 AM, revealed weekly skin assessments were completed by Unit Managers, Nursing Team Leaders and Nursing Management. Per interview, each had a group of residents they assessed and any injuries of unknown source were to be looked into. She reported however, there were no injuries of unknown source observed during the skin assessment audits. The DON indicated she and the Administrator reviewed the skin assessment audits, and the audits were taken by her to the QA meeting on 12/22/14. She revealed the skin assessment audits would continue weekly. Review of the QA Meeting sign-in sheet revealed there was a meeting dated 12/22/14 with all Department Heads present. 4. Review of the statement, signed by the Corporate Nurse, dated 12/22/14, revealed on 12/18/14 she activated a Routine Behavior | F 226 | | | |

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| F 226 | <p>Continued From page 86</p> <p>Monitor for Point of Care, the facility's electronic charting system, and an as needed option for every resident at the facility. Review of Resident #1's Kardex/Nurse Aide Care Plan revealed it was revised to reflect the resident's behavior/mood and included revised interventions for CNAs to assist with resident's care regarding behaviors.</p> <p>Review of the Performance Improvement (PI) Worksheet audit, revealed all residents' with behaviors were assessed for the Kardex being current with appropriate interventions for residents, and if the answer was no, the Kardex was updated.</p> <p>Review of the audit of residents with assessed behaviors, dated 12/19/14, revealed all their care plans were reviewed to ensure Behavior Comprehensive Care Plans were in place.</p> <p>Interview with the RN/MDS/RAI Coordinator, on 12/24/14 at 9:31 AM, revealed she had worked with the Corporate Nurse to ensure residents' behavior care plans would flow to the CNAs' Kardex on the facility's electronic charting system. She stated she reviewed all the residents' care plans and updated as needed.</p> <p>5. Review of the facility's PI Worksheets revealed on 12/19/14 and 12/20/14, files pertaining to abuse and self-reports were reviewed for the past thirty (30) days by the Administrator or Corporate staff. Resident #1's and Unsampled Resident C's investigations were reviewed with the following areas addressed: evidence of allegation; safe/secure resident-immediate report to DON/Administrator; alleged perpetrator removal; required initial notifications within time frame; staff was</p> | F 226 | |

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| F 226 | <p>Continued From page 87</p> <p>interviewed; Residents were interviewed; Social Service Assessments were completed; and education performed. On 12/21/14, any additional files which were generated from the auditing process were reviewed for the same information.</p> <p>Review of CNA #1's personnel file revealed she was terminated on 11/28/14.</p> <p>Interview with the CCO, on 12/24/14 at 11:14 AM, revealed when looking at the investigation related to the alleged abuse of Resident #1, he knew it was not good when CNA #1 completed her shift caring for residents, after the alleged abuse. He revealed staff should have reported the incident immediately. The CCO stated management reviewed Resident #1's investigation and agreed with the findings CNA #2 should have reported the witnessed incident of alleged abuse on 11/25/14 immediately after it occurred. Continued interview revealed they further looked over the investigation to see where the facility failed.</p> <p>6. Review of the facility's PI Worksheet, dated 12/19/14 from 12:00 PM to 5:00 PM, revealed the Medical Records Director and the Business Office Coordinator audited 100% of the facility staff's personnel files. Continued review revealed the personnel files were checked for current license verification, Abuse Registry Check Registration, Criminal Background Check, and Kentucky Caregiver Misconduct Registry check. All personnel files were found to be 100% compliant.</p> <p>Review of three (3) personnel files for employees, CNA #11, LPN #9, and the Social Worker revealed the files contained the audited</p> | F 226 | | |
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| F 226 | Continued From page 88 documentation indicating compliance. Interview with the Business Office Coordinator, on 12/23/14 at 3:19 PM, revealed she audited current facility staffs' personnel files to make sure they had the necessary documentation for compliance. She stated her findings were reported to the Administrator on 12/19/14, and to the QA Committee on 12/22/14. Continued interview revealed for new hires the background checks were done prior to the employee coming into the building. Interview with the Administrator, on 12/24/14 at 10:23 AM, revealed for preventing abuse the process began with pre-employment screening. He reported staffs' personnel files had to be 100% compliant in the areas of Abuse, Criminal Background Checks, and with the Kentucky Caregiver Misconduct Registry. The Administrator reported he reviewed the results of the audits completed by the Business Office, and would continue to review newly hired staffs' files to ensure they were compliant with the required documentation. 7. Review of the facility's Abuse/Neglect/Misappropriation of Property policy revealed the policy was revised December 2014, for incidents involving residents, to indicate staff must "immediately report the incident to a supervisor on duty". Interview with the Administrator and DON, on 12/24/14 at 10:23 AM, revealed on 12/19/14, the CCO met with the Administrator, DON, Medical Director, the Nursing Leadership Team, and other Corporate Staff to discuss the identified concerns and the facility's abuse policy, to address the | F 226 | | | |

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| F 226 | <p>Continued From page 89</p> <p>concerns identified. Per interview, they came up with a plan to educate the staff, and also discussed prevention and how the facility got to "this" point.</p> <p>8. Review of the In-Services, dated 12/19/14 and 12/21/14, revealed the CCO and CRM educated the Administrator, DON, ADON, Unit Managers and Department Heads regarding the results of survey, the federal regulations and interpretive guidelines for tags, F223, F225, and F226, the facility's root cause analysis of the deficient practice and the newly revised abuse policy. Review revealed Department Heads were inserviced in a "Train the Trainer" manner regarding "Team Member" education covering abuse prevention, abuse reporting, investigations, Comprehensive Care Plans, the Kardex and the newly revised abuse policy.</p> <p>Interview on 12/23/14 with: the Business Office Coordinator at 3:19 PM; Social Service Assistant/Activity Director #1 at 5:20 PM; and the RD at 6:06 PM; and on 12/24/14 with the Social Services Director at 10:05 AM revealed they were all inserviced on 12/19/14 and 12/22/14 in the "Train the Trainer" fashion as per the AOC. They all stated they were then able to inservice other staff. Per interview, they had to receive a score of 100% to pass the post-test.</p> <p>Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed the CCO and CRM had trained them and all the Department Heads on 12/19/14 and 12/21/14, on abuse prevention, abuse reporting, investigations, Comprehensive Care Plans, the Kardex and the newly revised abuse policy Abuse in a "Train the Trainer" fashion, on 12/19/14. Per interview, all</p> | F 226 | | |
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who were educated were required to achieve a 100% passing score on the post-test and had done so. Continued interview revealed the main changes to the abuse policy was to provide the term "immediately", which staff was educated on not to assume someone else reported the alleged abuse. They stated a question and answer session was performed after the education on 12/21/14, to determine the education was effective.

Interview with the CCO, on 12/24/14 at 11:14 AM, revealed he had looked at what the facility "failed" to do or where the facility had "failed" and addressed that through educating the Department Heads in a "Train the Trainer" fashion.

9. Review of the Inservice sign-in sheets dated 12/19/14 through 12/22/14, revealed staff was educated on abuse prevention, abuse reporting, investigations, Comprehensive Care Plans, the Kardex, the newly revised abuse policy and ensuring concerns were "immediately" reported. Review of the post-tests revealed staff achieved 100%.

Interview on 12/23/14 with: CNA #2 at 9:22 AM; CNA #14 on 12/23/14 at 3:51 PM; Occupational Therapist (OT) #1 at 4:38 PM; Dietary Aide #1 at 4:54 PM; Laundry Assistant #1 at 5:05 PM; Activity and Social Services Assistant #1 at 5:20 PM; RN #3 at 5:38 PM; CNA #4 at 6:59 PM; CNA #16 at 7:12 PM; CNA #13 at 7:24 PM; LPN #8 at 7:33 PM; RN #5 at 7:48 PM; and on 12/24/14 with: RN #4 at 8:25 AM; CNA #8 at 8:58 AM; CNA #12 at 9:05 AM; CNA #17 at 9:27 AM; and, CNA #15 at 4:05 PM revealed they all were recently inserviced by a Department Head or Supervisor. They all reported the inservice was regarding the

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revised abuse policy, abuse prevention, investigations, and care plans related to the "Kardex". Per interview, the policy was accessible and could be found behind the nurse's station and in the break room. Staff stated the revised abuse policy stated to immediately report concerns to a supervisor as soon as the alleged abuse was observed. Continued interview with CNAs revealed they were familiar with the revision to their "Kardex" in which resident's behavior/mood was added. Dietary Aide #1 and Laundry Assistant #1 revealed they were not inserviced on the care plans/Kardex because they do not work directly with residents. All staff revealed they were given a post-test and had to have a passing score of 100%. Continued interview with staff revealed they continued to be questioned by management regarding the abuse policy, and CNAs stated they were being questioned regarding whether they had their residents' Kardex on their person or not.

Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed no staff was allowed to work until they had received the required education. Per interview, all newly hired staff would receive the education prior to working in the facility through the interactive computer program which the Business Office Coordinator would track for completion. They stated the Business Office Coordinator would also monitor the annual mandatory abuse inservice education. Continued interview revealed staff would receive the "impromptu" education as necessary.

10. Review of the "Team Member Abuse Policy Audit" forms revealed staff were randomly being selected to answer questions related to abuse.

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F 226 Continued From page 92

Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed twenty (20) staff was being interviewed and observed daily to determine their knowledge of the revised abuse policy and ensure they were knowledgeable of abuse prevention, reporting, investigation, how to locate the policy and knew to report immediately to one (1) of them in person or per the phone. They reported the revised abuse policy had been placed in break rooms and nurse's stations for staff's accessibility.

Interview with the CCO, on 12/24/14 at 11:14 AM, revealed he along with upper management educated staff, up to twenty (20) a day and questioned them regarding the abuse policy. Continued interview with the CCO revealed an audit tool was being used, and an "Employee Roster" was checked with staff who were inserviced to ensure all staff was educated.

11. Review of the QA Committee sign-in sheet, dated 12/19/14 and 12/22/14 revealed the Medical Director, DON, Administrator, and other Department Heads signed the Sign-in Sheet. The agenda revealed they were scheduled to meet weekly for the next eight (8) weeks. Review revealed they discussed the survey results and the four (4) Immediate Jeopardy (IJ) tags, F223, F225, F226 and F282. Continued review revealed they discussed QA audits to be implemented, which included personnel files, review of facility investigations in the last thirty (30) days, skin assessments of residents, psychosocial assessments of residents, staff interviews/assessments, staff training, and staff implementation of residents' Comprehensive Care Plan and Kardex. The facility's abuse policy and procedure was also reviewed, and the

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F 226 Continued From page 93 reporting system reviewed.

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Interview with the Administrator on 12/23/14 at approximately 2:40 PM, revealed the QA Committee met to discuss the deficiencies on 12/19/14 and 12/22/14. He reported they discussed the results of the survey and compliance through the audits to be implemented, such as in-servicing staff, reviewing personnel files, review of facility investigations in the last thirty (30) days, skin assessments of residents, psychosocial assessments of residents, staff interviews/assessments, staff training, and staff implementation of residents' Comprehensive Care Plan and Kardex. The Administrator indicated the facility's abuse policy and procedure was also reviewed.

12. Review of the inservice education from 12/19/14 through 12/22/14, revealed nursing staff and the IDT was provided education regarding residents' Comprehensive Care Plans and Kardex to ensure they were updated as necessary and staff implemented the residents' interventions. Continued review revealed the education was provided by the DON, ADON, Corporate RN, RN Managers and/or Team Lead Nurses.

Interview, on 12/23/14 at 5:38 PM with RN #3, a Unit Manager, revealed she was part of the Nursing Leadership Team, and had assisted with providing the education to nursing staff and the IDT from 12/19/14 through 12/22/14.

Interview on 12/23/14 with: OT #1 at 4:38 PM; LPN #8 at 7:33 PM; RN #5 at 7:48 PM; and, on 12/24/14 with RN #4 at 8:25 AM revealed they all had received the education provided from

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| F 226 | <p>Continued From page 94</p> <p>12/19/14 through 12/22/14. Per interviews, the education included information regarding residents' Comprehensive Care Plans, the Kardex and ensuring these were updated and ensuring staff implemented the interventions.</p> <p>Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed the education had been provided as per the AOC.</p> <p>13. Review of the audits of residents' care plans for behavior from 12/19/14 through 12/22/14 revealed they were performed by the RN/MDS/RAI Coordinator, MDS Licensed Nurses, the Corporate RN and/or Social Services Director. Review revealed the care plans were updated as necessary.</p> <p>Review of the Inservice Attendance Sheet, dated 12/19/14 and ongoing, revealed staff signatures indicating they had received the Care Planning education.</p> <p>Review of the facility's PI Worksheet audit for the Kardex, revealed staff were being observed and interviewed regarding the following: CNAs had their residents' Kardex on their person; and CNAs knew how to use the Kardex.</p> <p>Interview on 12/23/14 with: CNA #2 at 9:22 AM; CNA #14 on 12/23/14 at 3:51 PM; CNA #4 at 6:59 PM; CNA #16 at 7:12 PM; CNA #13 at 7:24 PM; and on 12/24/14 with: CNA #8 at 8:58 AM; CNA #12 at 9:05 AM; CNA #17 at 9:27 AM; CNA #15 at 4:05 PM revealed they all were recently inserviced on care plans related to the "Kardex". Per interview, they were familiar with the revision to their "Kardex" in which resident's behavior/mood was added. Continued interview</p> | F 226 | | |
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| F 226 | Continued From page 95 revealed they continued to be questioned by management regarding whether they had their residents' Kardex on their person or not. Interview with the RN/MDS/RAI Coordinator on 12/24/14 at 9:31 AM, revealed she had trained staff on how to track and monitor resident's behavior and informed them of the additional behavior plan added to the Kardex. She revealed CNAs were informed to advise nursing staff if there were any changes in the resident's behavior and how to document the behavior in the facility's computerized charting system. Per interview, she looked through residents' care plans the first time, then the DON and Unit Managers checked the resident's care plans and Social Services looked through them as well to ensure appropriate interventions were in place. Interview with the Administrator and DON, on 12/24/14 at 10:23 AM, revealed the CNAs' Kardex was being reviewed daily and updated as needed. They further revealed that CNAs were providing input other staff might not be aware of regarding a resident's behavior. Per interview, rounds were being performed by them, the Unit Managers, Team Lead Nurses and/or Clinical Department Heads to interview and observe CNAs to ensure they had their residents' Kardex on their person and were knowledgeable of the Kardex and the resident's interventions. According to the DON, the results of the observations and interviews were to be reported to her. The DON revealed staff was inserviced on residents' care plans and Kardex's and were informed the care plan directed each resident's plan of care. She stated CNAs were educated on residents' Behavior/Mood being added to the Kardex and the interventions on how to deal with | F 226 | | |
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the resident's behaviors. She revealed the Kardex's were to be reviewed and revised as necessary, and printed out for the CNAs.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=J

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure residents' Comprehensive Care Plan interventions were implemented to ensure the resident's safety from abuse for one (1) of five (5) sampled residents (Resident #1).

The facility assessed Resident #1 to be potentially verbally aggressive with staff for which the resident was care planned and interventions were in place. The care plan interventions stated if he/she became agitated, staff was to guide the resident away from the source of distress and if he/she became aggressive to walk calmly away and approach the resident at a later time. On 11/25/14, interviews with Certified Nursing Assistant (CNA) #1 and CNA #2 revealed the resident was "agitated" before and during his/her shower; however, they were not familiar with Resident #1's care plan interventions and proceeded with the shower anyway. CNA #2 and Nurse Aide in Training (NAT) #1, who were in the shower room with CNA #1, witnessed CNA #1

F 226 F282

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- Resident #1 was assessed by the Director of Nursing on 11/26/14 about occurrence in shower. RN performed full skin assessment on 11/26/14 with no findings related to the occurrence of 11/25/14. Licensed Social Worker on 11/26/14 and 12/18/14 assessed and has provided support to resident who has voiced no concerns with the staff/shower incident that occurred and has had no concerns of any other staff member abuse. MDS nurse completed comprehensive assessment of resident on 12/19/14 and noted no concerns, nor any difficulties with late effects of occurrence of 11/25/14. Comprehensive care plans and Kardex (CNA Care Plan), verified on 12/20/14 by DON, reflect individualized approaches to manage behaviors.
- Resident resides at facility, visited often by wife, assessed by licensed nursing staff and social worker to be safe and secure.
- On 12/18/14 the facility's electronic charting system was modified by the Corporate Nurse to list/show interventions for residents' behaviors on the Kardex (CNA care plan). Each, resident Kardex was updated automatically.

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| F 282 | <p>Continued From page 97</p> <p>intentionally spray Resident #1 in the face with hot and cold water after the resident called her a name. CNA #2 and NAT #1 also heard the resident yelling for CNA #1 to "stop" she was "burning" him/her. (Refer to F223)</p> <p>The facility's failure to have an effective system in place to ensure the Comprehensive Care Plan was implemented to ensure residents' safety from abuse was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/18/14, and determined to exist on 11/25/14. The facility was notified of the Immediate Jeopardy on 12/18/14.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 12/23/14, with the facility alleging removal of the Immediate Jeopardy on 12/23/14. The Immediate Jeopardy was verified to be removed on 12/23/14, as alleged, with remaining non-compliance in the area of 42 CFR 483.20, Resident Assessment, F-282 Qualified Professionals, with a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Interview, on 12/18/14 at 2:06 PM, with the Administrator revealed the facility had no policy regarding residents' care plans; however, the facility used the Resident Assessment Instrument (RAI) User Manual Version 3.0 as a guideline for Comprehensive Care plans.</p> <p>Review of the RAI User Manual Version 3.0, dated May 2013, revealed the Comprehensive</p> | F 282 | <p>By 12/19/14 the RN MDS RAI Coordinator reviewed all residents to ensure Behavior Comprehensive Care Plans are in place for each resident.</p> <p>On 12/19-22/14 each resident Kardex (CNA Care Plan) was printed and reviewed by the Direct Care Staff (Licensed nurses, CNA's, Unit Managers and/or Social Services Director) to identify residents with behaviors/needs for care planning.</p> <p>On 12/19-22/14 the RN RAI Coordinator, MDS licensed nurses, Corporate RN, and/or Social Service Director reviewed each resident care plan for Behavior to assure interventions were appropriate and flows automatically to the Nurse Aide Care Plan (Kardex) based on feedback and assessment by the Directed Care Staff (Licensed Nurses, CNA's, Unit Managers and Social Service Director); they were updated as indicated.</p> <p>Findings were reviewed with DON and Administrator on 12/22/14 and will be reported to the QA committee on 12/22/14 by the DON.</p> <p>Nurse aide Kardex's are printed off each day by the Charge Nurse and</p> | |
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Care Plan was an interdisciplinary communication tool which must include measurable objectives and time frames, and must describe the services to be furnished to attain or maintain a resident's highest practicable, physical, mental, and psychosocial well-being. Additionally, per the Manual, the services provided or arranged must be consistent with each resident's written plan of care.

Review of Resident #1's medical record revealed the facility admitted him/her on 01/21/13, with diagnoses which included Depressive Disorder and Insomnia. Review of the resident's Annual Minimum Data Set (MDS) Assessment, dated 10/21/14, revealed the facility assessed the resident to be moderately cognitively impaired, and was not assessed to have behaviors. However review of Resident #1's Comprehensive Care Plan revealed a care plan for the resident which stated he/she had the potential to be verbally aggressive with staff and his/her spouse which was initiated on 08/01/14 and revised on 08/28/14. Review of the behavior care plan revealed the interventions included CNAs were responsible: when the resident became agitated they should intervene before the agitation escalated; guide the resident away from the source of distress; engage the resident calmly in conversation; if the resident's response was aggressive, staff should walk calmly away and approach later; give the resident as many choices as possible about care and activities; and, monitor his/her behaviors as needed.

However, review of Resident #1's Kardex (the CNA care plan), undated, revealed no documented evidence Resident #1's behavior/mood interventions were added to the

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reviewed for accuracy and need to update. Verbal report and Kardex for reference is given to each CNA to ensure the direct care staff is aware of the interventions in place for the residents. Nurse aides are aware to communicate to verbally or via the Kardex to the nurses any concerns or need for further assessment/update of the resident/care plan/Kardex. These Kardex's are reviewed by the Charge Nurse for change of the Plan of Care for the Resident.

3. On 12/19/14-12/22/2014 the Director of Nursing, Assistant Director of Nursing, Corporate RN, RN Managers or Team Lead Nurses provided additional in-service/education to the Nursing staff and IDT on the Comprehensive Care Plan and communication of interventions to the Nurse Aide Care Plan for implementation. Included in this training was the importance of accessing the Kardex, communicating changes needed to maintain an accurate and updated Plan of Care (including Kardex) for the residents.

On 12/19/14-12/22/14 all staff (licensed nurses, certified nurse aides, licensed therapy staff, social service, activity, dietary, housekeeping, business office and

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CNA's Kardex/Care Plan to ensure they were aware of the interventions.

Interview with Resident #1, on 12/17/14 at 4:58 PM, revealed he/she believed staff did not know how to care for him/her. Resident #1 stated he/she received showers twice a week, but did not enjoy showers. Per interview, his/her showers were a "joke", and he/she had experienced "better showers in Korea".

Interview with CNA #1, on 12/17/14 at 2:35 PM, revealed the resident was always combative when she gave him/her a shower. Per interview, on 11/25/14 when she was escorting Resident #1 to the shower, the resident was grabbing at her clothes, and indicated he/she was agitated. CNA #1 stated she asked NAT #1 to assist her with getting Resident #1 in the shower chair. She stated once Resident #1 was in the shower she could not de-escalate the resident's behaviors. Continued interview revealed she did not know for certain if Resident #1 was care planned for behaviors or what interventions were in place for the resident. CNA #1 reported Resident #1 would often have behaviors and she would report it to the nurses. She stated, however, she believed the nurses would "shrug off" Resident #1's behaviors and would tell her the behavior was normal and to just "do her job". According to CNA #1, residents' Kardex/CNA Care Plan only informed CNAs how to assist residents with their Activities of Daily Living (ADL's), but did not address residents' behaviors. Further interview revealed she was not aware there was a concern regarding the care she provided Resident #1 on 11/25/14, until the Director of Nursing (DON) approached her and asked her to write a statement concerning the shower room

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maintenance) was provided in-service education by the Corporate Compliance Officer, Administrator, DON or Trained Trainer Department Head which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and reporting concerns immediately. Evidence of learning measured via written post-test; 100% accuracy required.

4. A Quality Assurance meeting was held on 12/19/14 with the Medical Director, Director of Nursing, Administrator and other members of the Quality Assurance Committee. The findings of the state survey as well as deficiencies, including scope and severity, were discussed. Action plans to address each deficiency as well as the overall system were developed and approved by the QA Committee. On 12/22/14 a second full Quality Assurance meeting was held to review the action plans to remove immediate jeopardy. Findings of all observations and interviews, compliance with in-servicing and results of monitoring were analyzed and discussed. Findings will be reported by the DON, Administrator or Social Services Director and followed by each with Committee recommendations. QA

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| F 282 | Continued From page 100 allegations. CNA #1 reported she did not return to work with caring for residents and was terminated on 11/28/14. Interview with CNA #2, on 12/17/14 at 3:30 PM, revealed she was unaware Resident #1 was care planned for behaviors, and she thought only a resident's family or the nurses had access to residents' care plans. Per interview, she stated she had observed CNA #1 being "stern" with residents before. If a resident refused a shower, CNA #1 would say, "you know you really should take a shower". According to CNA #2, this was what happened on 11/25/14, and what escalated the situation for Resident #1 that day, as the resident told CNA #1 he/she did not want to take a shower. CNA #2 stated Resident #1 then became "agitated" and remained that way during his/her shower. Continued interview revealed during the shower Resident #1 called CNA #1 a "nasty" name and CNA #1 "squirted" the resident in the face with water. She stated Resident #1 did not become violent until that happened. Per CNA#2, she and CNA #1 should have stopped Resident #1's shower, taken the loss of giving him/her a shower that day or tried approaching the resident to take it later on that day. Interview with NAT #1, on 12/17/14 at 1:09 PM, revealed Resident #1 had behaviors at times which included loud screams, calling staff names, and he/she would "fight" a bit when staff were transferring him/her. NAT #1 stated staff could de-escalate Resident #1's behaviors however, by talking calmly to the resident, and his/her behaviors could be prevented in this way before behaviors started. Per NAT #1, he was provided very little training from the facility, and did not know what the Kardex/CNA Care Plan was, and | F 282 | Committee recommends Allegation of Compliance – removal of immediate jeopardy date by 12/23/14. Resident's Kardex are printed daily by the nurse. Resident Kardex's will be reviewed/updated daily by nurses, Unit Managers, MDS nurses, Team Lead nurses and/or Therapist to assure they are current and provide appropriate interventions for the resident. If Kardex not current, licensed staff will update and ensure the STNA has an updated copy. Results of the observations and interviews will be reported the DON. (See Attached as Exhibit D) Observation and Interview audit will be performed by the Administrator, DON, RN Unit Manager, Team Lead Nursing Staff, and/or licensed clinical Department Heads daily. Administrator, DON, RN Unit Manager, Team Lead Nursing Staff, and/or licensed clinical Department Heads will ensure Direct Care Staff have the printed Kardex on their person and able to use it. They will also reinforce and ensure All Staff are aware of the Abuse/Neglect/Misappropriation of Property policy revisions, know what and how to report, and have access to the Administrator/DON | | |

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| F 282 | Continued From page 101 had "never used it" before. NAT #1 revealed on 11/25/14 around 3:00 PM, he had assisted CNA #1 per her request to get Resident #1 into the shower. He stated he, CNA #1 and CNA #2 were present when CNA #1 began Resident #1's shower. NAT #1 stated he heard Resident #1 yell over and over again during the shower, "stop you're burning me", and saw CNA #1 spray the resident in the face with water. According to NAT #1, CNA #1 told Resident #1 if he/she would listen to her, she "wouldn't have to do this." NAT #1 revealed he told CNA #1 to stop, and she told him to take over which he did. He stated he adjusted the water temperature and gave the shower hose to Resident #1, and CNA #1 then told him to "get the fuck out of here". NAT #1 reported he told CNA #1 to "be good to" Resident #1, and he then left the shower room to return to work on his hall. Further interview revealed NAT #1 indicated that if CNA #1 had spoken calmly to Resident #1 prior to and during the shower it might have prevented the incident. NAT #1 stated he did not tell anyone what he had witnessed in the shower room until around 5:30 PM. Interview with CNA #4, on 12/17/14 at 11:20 AM, revealed she had cared for Resident #1 before, and he/she had behaviors which included cursing at staff. She stated Resident #1 had not been combative with her recently, but had been in the past. CNA #4 revealed she learned how to de-escalate Resident #1 by talking calmly with him/her which would calm the resident. Continued interview revealed she was not certain if Resident #1 was care planned for behaviors, but knew the resident's behaviors were not on his/her Kardex/CNA Care Plan. She stated the Kardex only contained information on how to | F 282 | contact information as well as the policy itself. Findings will be reported to the DON and Administrator. Findings will be reported to the QA committee on 12/22/14 by the Administrator. (See Attached as Exhibit E). The Interdisciplinary Team consists of Administrator, DON, Social Worker, Licensed Dietician, Chef, Maintenance Director, Activities Director, Medical Records Director, Business Office Coordinator, Housekeeping Supervisor, RN Unit Managers, and other Department Heads. The Interdisciplinary Team has daily "Stand Up" meetings on Monday - Friday lead by the Administrator and DON. These will be on-going. Any concerns, changes, etc. are addressed as needed and reported to the IDT the following meeting day. The QA team consists of the Medical Director, DON, Administrator and Departments Heads. All monitoring/audit results are reviewed by the QA Team with appropriate follow-up required as needed. QA meetings were held on the following dates: 12/19/14, 12/22/14, 12/23/14, 12/29/14, 1/5/15, 1/12/15, and 1/19/15. QA Committee meetings will continue weekly for 8 weeks and then the frequency will be determined by | |
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| F 282 | <p>Continued From page 102 assist residents with their daily care.</p> <p>Interview, on 12/17/14 at 4:34 PM, with CNA #7 revealed she had cared for Resident #1 before, and was aware he/she had behaviors of screaming and hollering at times. Per interview, the Kardex gave the CNAs some information, but it was only related to residents' ADLs. She stated the Kardex did not contain information regarding residents' behaviors or what to do about behaviors. Further interview revealed she was "not for sure" if CNAs had access to residents' care plans.</p> <p>Interview, on 12/17/14 at 5:26 PM, with CNA #8 revealed CNA #1 never really ever gave residents an option when it came to their care, and CNA #1 was "kind of rough with" residents. Per interview, CNAs could use the Kardex, but she was "not sure" if it listed behavioral interventions on it. She stated the nurses were supposed to make copies of the Kardex for CNAs to carry with them; however, this was not done. CNA #8 stated the nurses had never really talked to the CNAs about Resident #1's behaviors or what to do if he/she had them. She stated CNAs did not have access to residents' care plans.</p> <p>Interview, on 12/17/14 at 6:30 PM, with CNA #6 revealed she had cared for Resident #1 before, and was aware he/she had behaviors of screaming out when he/she was changed; however, she stated Resident #1 was "in pain a lot". She stated she did not know what interventions CNAs were supposed to use with Resident #1 when this occurred, she just tried to talk calmly to him/her. CNA #6 revealed she had observed CNA #1 "yell" at residents before, including Resident #1, which she reported to the</p> | F 282 | <p>QA Committee with a minimum of quarterly.</p> <p>All monitoring findings will be reviewed at Quality Assurance Meetings that will take place weekly, until facility is in Substantial Compliance, when that occurs, the QA Committee will decide on frequency of meetings with a minimum of Quarterly, in order to keep facility in Substantial Compliance. QA team consists of Medical Director, DON, Administrator and Departments Heads. Facility will perform audits on Kardex after substantial compliance at least weekly x 4 weeks and monthly until results can be reported at quarterly QA meeting.</p> <p>5. Date of Compliance: The facility has continued to execute all audits, preventative measures, policy revisions and monitoring of performance developed via the AOC and POC process. Analysis of the whole, via QA meetings, indicates our system is working and substantial compliance alleged 1/12/15.</p> |

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| F 282 | Continued From page 103 nurses who reported it to the DON. CNA #6 stated nothing was done though; however, if the DON had done something the 11/25/14 shower room incident might not have occurred. She stated CNAs used to have sheets which noted residents' care needs; however, CNAs hadn't had these sheets "for about two (2) months now". According to CNA #6, the computerized system gave CNAs information on the residents' "physical care needs", such as how to transfer, whether they were continent or incontinent or dietary status. CNA #6 stated it was hard to know what kind of care residents needed as nurses "never" gave CNAs report. She revealed the nurses "should do that though" so CNAs would know what the residents needed. Further interview revealed CNAs did not have access to residents' care plans; and, therefore, did not know what interventions were in place. Interview, on 12/17/14 at 5:41 PM and at 6:25 PM with Licensed Practical Nurse (LPN) #4 revealed CNAs had a Kardex to use for residents' care which they were supposed to "carry" with them at all times. She stated residents' Kardex's were printed out each night by the night shift nurses, and copies were stored in a drawer at the nurse's station. The LPN stated the CNAs got a copy of the Kardex at the beginning of their shift. LPN #4 stated however, the Kardex did not have interventions on them for the CNAs to know what to do for residents. Interview, on 12/17/14 at 9:25 PM with Registered Nurse (RN) #2 revealed CNAs had an "online" care plan to use for residents' care which the CNAs were supposed to "check" each day after they received their resident assignment. According to RN #2, she had cared for Resident | F 282 | | | |

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F 282 Continued From page 104
#1 and he/she had behaviors of calling CNAs "foul" names at times. Per interview, CNAs did not "normally" get report from the nurses, but she did try to give them report if a resident was more confused than normal or if a urine or stool specimen needed to be obtained. She stated she didn't think the "online" care plan addressed residents' behaviors "specifically" and didn't know if the CNAs had access to interventions for residents with behaviors. However, she stated CNAs were trained on behaviors in their nurse aide training program, so they should know how to deal with residents' behaviors.

F 282

Interview with the Minimum Data Set (MDS) Coordinator, on 12/18/14 at 11:44 AM, revealed upon admission nursing staff assessed residents and a basic care plan was developed after the assessment. The MDS Coordinator stated after twenty-one (21) days, the residents had a Comprehensive Care Plan developed with interventions to be implemented. Per interview, CNAs should follow their Kardex, which was their care plan for residents' care needs. She stated Resident #1 did not trigger for behaviors on the MDS Assessment; however, he/she was care planned for behaviors due to a past history of verbal behaviors. According to the MDS Coordinator, if a resident triggered for behaviors a care plan would be "active" for the behaviors and would be on the CNAs Kardex. However, as Resident #1 did not trigger for behaviors and his/her care plan was based on a history of behaviors, the nurses should have opened a User Defined Assessment (UDA) in the facility's computerized charting system which was "kind of" a short term care plan. She stated it was important for staff to know residents' care plan and follow the interventions, and CNAs should

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F 282 Continued From page 105
follow the Kardex for their residents. Further interview revealed Resident #1's behavior care plan interventions should have been on the Kardex because if he/she was "agitated" it was important staff know what to do.

F 282

Interview with the Director of Nursing (DON), on 12/18/14 at 1:00 PM, revealed items triggered on the Comprehensive Care Plan might not always be on the CNAs Kardex, such as "behavior/mood". Continued interview revealed she reported she went over residents' care plans and interventions with nurses; however, she did not go over care plans and interventions with CNAs. The DON stated nurses reviewed residents' care plans with CNAs; however, this was not done every day. She revealed the CNAs could pull up residents' care plans through the facility's computerized charting system, Point Click Care (PCC). Per interview, she would expect CNAs would carry out interventions as they pertained to their residents' behaviors, as this was "common sense", and CNAs received training on how to deal with residents with behaviors. The DON stated residents' care plans were accessible to anyone as all they had to do was get on PCC to pull it up. She stated she did not believe CNA #1 followed Resident #1's care plan, but she should have done this.

The facility provided an acceptable Credible Allegation of Compliance (AOC) on 12/23/14 which alleged removal of the IJ effective 12/23/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was assessed by the DON on 11/26/14, regarding the occurrence in the shower. An RN performed a full skin assessment of

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| F 282 | Continued From page 106 Resident #1 on 11/26/14 with no findings related to the occurrence of 11/25/14. A Social Worker (SW) assessed Resident #1 on 11/26/14 and on 12/18/14 and provided support to the resident who voiced no concerns with the staff/shower incident and had no concerns of any other staff member abuse. A MDS Nurse completed a comprehensive assessment of Resident #1 on 12/19/14 and noted no concerns, nor any difficulties with late effects of the occurrence of 11/25/14. Resident #1's Comprehensive Care Plans and Kardex (CNA Care Plan), were verified on 12/20/14 by the DON to reflect individualized approaches to manage his/her behaviors. 2. On 12/19/14, each cognitively intact resident with a Brief Interview of Mental Status (BIMS) greater than or equal to eight (8) was observed and interviewed by the SW, Registered Dietician (RD), Activity Director and/or Director of Rehabilitation for resident concerns of any potential abuse, neglect or misappropriation. The findings of the interviews and observations were reported to the Administrator on 12/19/14. Any allegation/concern was immediately followed up on by the Administrator, with investigations completed, and notifications made, if indicated, by the Administrator. The findings were to be reported at the 12/22/14 Quality Assurance (QA) Committee meeting by the Business Office Coordinator. The SW was to continue to perform interviewable resident abuse observations and interviews weekly and report the findings to the QA team. 3. On 12/18/14 through 12/19/14, licensed nursing staff conducted head to toe assessments of each cognitively impaired resident, who had a BIMS less than eight (8) or was | F 282 | | | |

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| F 282 | Continued From page 107 non-interviewable, for any new or unusual bruises, skin tears etc., or other signs of potential abuse. There were no findings that would trigger an allegation of abuse. The results of the head to toe assessments were reviewed by the DON and Administrator, and the findings reported at the 12/22/14 QA meeting by the DON. The Nursing Management Team which included the DON, ADON, Unit Managers and Team Leads would perform head to toe assessments of each cognitively impaired resident weekly for any new/unusual bruises, skin tears etc., or other signs of potential abuse, with no findings that required action at the time. 4. On 12/18/14 the facility's electronic charting system was modified by the Corporate Nurse to list/show interventions for residents' behaviors on the Kardex (nurse aide care plan). Each residents' Kardex was updated automatically. By 12/19/14 the Registered Nurse (RN)/MDS/Resident Assessment Instrument (RAI) Coordinator reviewed all residents care plans to ensure Behavior Comprehensive Care Plans were in place for each resident assessed to require one. 5. On 12/19/14, the Administrator, Corporate Compliance Officer (CCO) and Corporate Risk Manager (CRM) reviewed each file of resident allegations of abuse or facility self reports of potential abuse in the past thirty (30) days to assure completeness and thoroughness of the investigation. If there were any concerns/gaps identified, they were followed up accordingly by the Administrator. On 12/21/14, the Administrator, CCO and CRM reviewed additional investigation files which were generated by the facility's observations and interviews completed | F 282 | | |
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| F 282 | Continued From page 108 on 12/19/14 through 12/20/14. This included, but was not limited to: immediate removal of any alleged or perpetrating staff from any care area; immediate reporting to the Administrator; interview of resident and staff; assessment of the alleged victim; and review of the investigation action ensuring it met the policy and federal requirements. The Administrator took action, if any required. The alleged perpetrator, CNA #1 was terminated on 11/28/14 after the completion of the facility's investigation. 6. On 12/19/14 all personnel files were audited by the Business Officer Coordinator and Medical Records Director for completion of pre-hire components used by the facility as part of screening and prevention of abuse. The files were found to be one hundred percent (100%) compliant, with evidence of: current License verification; Abuse Registry Check Registration; Criminal Background Check; and Kentucky Caregiver Misconduct Registry check. The findings of the audit were reported to the Administrator on 12/19/14 and were to be reported to the QA Committee on 12/22/14, by the Business Office Coordinator. The Business Office Coordinator and Administrator would review each new hire personnel file to assure verifications and background checks were completed prior to beginning work. 7. The facility's Abuse/Neglect/Misappropriation of Property Policy was reviewed on 12/19/14, which was in place at the time of the survey, addressing concerns identified by surveyors, by comparing it to federal regulations and interpretive guidelines and the contents of the facility's policy. The facility's Abuse/Neglect/Misappropriation of Property | F 282 | | | |

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| F 282 | Continued From page 109 Policy was revised on 12/19/14 by the Chief Operating Officer (COO), Vice President (VP) of Risk Management, and CCO. 8. On 12/19/14 the CCO inserviced the Administrator, DON, ADON, Unit Managers and each Department Head on the results of the survey, the facility's root-cause analysis of the deficiencies and the newly revised abuse policy and procedure. Additionally, on 12/19/14 the CCO inserviced each Department Head, in a "Train the Trainer" fashion, on the "Team Member" education which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and the revised policy. On 12/21/14 the CRM and CCO each provided additional education to the Administrator, DON, and Nursing Leadership Team on: review of federal regulations and interpretive guidelines for F223, F225, F226; additional review of the revision of the facility's policy on Abuse/Neglect/Misappropriation of Property; and root cause analysis of the survey findings related to systematic response to allegations. Evidence of the learning was measured via meaningful Question and Answer (Q & A) and discussion of cause examples and a repeat verbalization of understanding of definitions and the facility's system. 9. On 12/19/14 through 12/22/14 all staff including licensed Nurses, CNAs, licensed Therapists, Social Services, Activity, Dietary, Housekeeping, Business Office and Maintenance was provided inservice education, "Team Member" Education, by the CCO, Administrator, DON or Trained Department Head which covered | F 282 | | | |

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| F 282 | <p>Continued From page 110</p> <p>Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and reporting concerns immediately. The updated abuse policy was reviewed and referred to in all staff "Team Member" education in-services, performed from 12/19/14 through 12/22/14. Evidence of the staff member's learning was measured via a written post-test, with a 100% accuracy required. Any staff member who had not been at work, or was on leave or vacation would complete all education and training prior to working their next shift. No staff member would work without first being inserviced. All newly hired staff members would be provided inservice education on abuse prevention, identification and reporting during their orientation prior to working in the facility through the Interactive Computer Program with a post-test and review of the abuse policy signed for verification. The Business Office Coordinator would track completion.</p> <p>Annual mandatory inservice of abuse, including but not limited to prevention, would continue to be monitored by the Business Office Coordinator; additionally, as indicated by concerns or observations, impromptu inservices for staff would be held as decided by the Administrator, DON, and/or Ombudsman.</p> <p>Also, besides being directly taught to staff, the revised policy was placed in areas staff/team members typically congregate, take breaks and eat lunch.</p> <p>10. Beginning on 12/20/14, a random observation and interview of staff members was begun by the Administrator, Corporate support staff and Department Heads. The observations</p> | F 282 | | |
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| F 282 | Continued From page 111 and interviews were designed to detect if staff members were knowledgeable about prevention, reporting, investigation of abuse and how to locate and review the revised abuse policy. The facility was to perform interviews of at least twenty (20) staff members weekly until substantial compliance was obtained to ensure each allegation of abuse would be reported immediately by the staff to the DON or Administrator. If the DON or Administrator was not in the facility, staff would contact the DON or Administrator via phone for thorough/timely investigation and reporting. The Administrator would be notified immediately of any allegations. After substantial compliance was obtained, the QA team would determine the frequency of the staff interviews. The findings of each observation and interview developed for this Allegation of Compliance (AOC) were evidence of the operationalization of the facility's policy on abuse/neglect/misappropriation of property. All findings of observations and interviews would be reviewed by the QA Committee to ensure team members understood, implemented and operationalized the policy. 11. The QA team consists of the Medical Director, DON, Administrator and Department Heads. A QA meeting was held on 12/19/14 with the Medical Director, DON, Administrator and other members of the QA Committee. The findings of the State Survey Agency's findings, as well as, deficiencies, including the Scope and Severity, were discussed in the meeting. Action plans to address each deficiency, as well as, the overall system were developed and approved by the QA Committee. On 12/22/14, a second full | F 282 | | | |

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QA Committee meeting was held to review the action plans to remove the Immediate Jeopardy. Findings of all observations and interviews, compliance with inservicing and results of monitoring were analyzed and discussed. The findings would be reported by the DON, Administrator or Social Service Director and followed by each with Committee recommendations. QA meetings would take place weekly, until the facility was in substantial compliance, and when that occurred the QA Committee would decide on the frequency of meetings with a minimum of quarterly, in order to keep the facility in substantial compliance.

12. From 12/19/14 through 12/22/14, the DON, ADON, Corporate RN, RN Managers and/or Team Lead Nurses provided additional inservice/education to the Nursing staff and Interdisciplinary Team (IDT) on the Comprehensive Care Plan and communication of interventions to the Kardex/Nurse Aide Care Plan for implementation. Included in this training was the importance of accessing the Kardex, communicating changes needed to maintain an accurate and updated Plan of Care, including the Kardex, for each of the facility's residents.

13. On 12/19/14 through 12/22/14, the RN/MDS/RAI Coordinator, MDS Licensed Nurses, the Corporate RN, and/or Social Service Director reviewed each residents' care plan for Behavior to assure interventions were appropriate and flowed automatically to the Kardex (nurse aide care plan) based on feedback and assessment by the direct care staff which included the CNAs, licensed Nurses, Unit Managers and Social Service Director. The care plans were updated as indicated. The findings

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| F 282 | Continued From page 113 were reviewed with the DON and Administrator on 12/22/14 and would be reported to the QA Committee on 12/22/14 by the DON. The Kardex's were to be reviewed and updated daily by the Charge Nurses, Unit Managers, MDS Nurses, Team Lead Nurses and/or Therapists to assure they were current and provided appropriate interventions for each resident. The Kardex was to be printed off each day by the Charge Nurse and a copy of the Kardex given to the CNAs. The Kardex copy and verbal report from the nurse was given to each CNA to ensure the direct care staff was aware of the interventions in place for each of the facility's residents. If the Kardex was not current, licensed staff would update it and assure the CNA had the updated copy. CNAs were made aware they were to communicate verbally or via the Kardex to the nurses any concerns or need for further assessment or update of the resident's care plan/Kardex. Resident #1's Kardex was reviewed by the Charge Nurse for changes of the Plan of Care for the resident. Observation and interview rounds will be completed by the Administrator, DON, Unit Manager, Team Lead Nurses and/or licensed Clinical Department Heads to ensure each direct care staff person had the Kardex copy on their person and was able to use it. Results of the observations and interviews would be reported to the DON. The DON would report the findings at the 12/22/14 QA meeting. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Review of Resident #1's skin assessment, | F 282 | | |
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| F 282 | <p>Continued From page 114</p> <p>dated 11/26/14, revealed no open areas or bruising noted. Review of the Social Services Note, dated 12/19/14 revealed a late entry from the Social Worker to address her interview with the resident on 11/26/14 to discuss the incident/alleged abuse on 11/25/14. Continued review of the Social Service Notes, dated 12/18/14 and 12/19/14, revealed the Social Service Director followed up with the resident to assess Resident #1's psychosocial well-being. Review of Resident #1's Comprehensive Assessment, dated 12/19/14, revealed the resident was assessed by Licensed Practical Nurse (LPN) #7/MDS Nurse with no concerns identified. Review of Resident #1's Kardex revealed a Behavior/Mood care plan was added to the Kardex. Review of Resident #1's Comprehensive Care Plan revealed the resident's care plan was revised on 12/19/14 for staff to analyze key times, places, circumstances, triggers, and what de-escalated his/her behavior and document the information, as the resident was noted to have increased anxiety with showers and when his/her spouse had left for the day.</p> <p>Interview with the DON, on 12/24/14 at 10:23 AM, revealed Resident #1 was assessed "that night" (11/25/14) and Social Services continued to follow up with the resident. She stated Resident #1 resident was assessed again on 12/18/14 and his/her care plan was updated/revised. She reported she reviewed the resident's updated/revised care plan and verified it was complete regarding the changes that needed to be reflected on his/her care plan. She further stated the CNAs' Kardex had been updated with the changes. Continued interview with the DON revealed the SSD also assessed the resident on</p> | F 282 | | |
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12/18/14 and had been following up with the resident by reviewing his/her care plan.

Interview with the SSD, on 12/24/14 at 10:05 AM, revealed she talked to Resident #1 on 12/18/14, and had followed up with him/her since. Continued interview revealed Resident #1's care plan was updated related to his/her behavior and bathing.

2. Review of the facility's Resident Rights/Abuse Prevention/Comprehensive Care Plans Audit Worksheets, dated 12/18/14 and 12/19/14, revealed residents with a BIMS score of eight (8) or higher were interviewed by the Director of Social Service, RD, Activity Director and/or Director of Rehabilitation. Two (2) residents, Unsampled Resident A and Unsampled Resident B, who also resided on Resident #1's unit expressed concerns on 12/21/14, regarding staff, these concerns were not abuse related. The residents' concerns were related to staff not being able to work together to provide care, and staff not taking the time to talk to them. Continued review of the audit revealed the Administrator followed up with the two (2) residents on 12/22/14.

Interview on 12/24/14, with Unsampled Resident A at 9:30 AM and Unsampled Resident B at 9:40 AM, revealed they were questioned by staff regarding any concerns they had of abuse by staff; however, neither resident expressed concerns regarding abuse.

Interview with the Social Services Director, on 12/24/14 at 10:05 AM, revealed she interviewed all of the interviewable residents with a BIMS score of eight (8) or higher on all the facility's

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units. She reported there were no concerns of abuse given. The Social Services Director stated the Administrator followed up on some residents' concerns which were not related to abuse. Per interview, the interviewable residents would continue to be interviewed regarding any abuse concerns, and observations performed at the time of interview to ensure the residents had no signs or symptoms of abuse.

Interview, on 12/23/14 at 3:19 PM, with the Business Office Coordinator revealed the findings of the audits were reported to the QA Committee on 12/22/14.

Interview, on 12/24/14 at 10:23 AM, with the Administrator revealed the findings of the interviews and observations were reported to him on 12/19/14, and continued to be reported.

3. Review of the skin assessments, dated 12/19/14, of residents identified as having a BIMS of seven (7) or less and non-interviewable residents revealed they were assessed by nursing staff who included RN #4, LPN #8, the ADON and LPN #7. Review of the skin assessments revealed no new or unusual bruising, no concerns were noted.

Interview with LPN #8, on 12/23/14 at 7:33 PM, revealed she did skin assessments for residents who had a BIMS of seven (7) or less, or who were non-interviewable. She stated she assessed the residents on 12/19/14, and no concerns were observed or noted.

Interview with the DON on 12/24/14 at 10:23 AM, revealed weekly skin assessments were completed by Unit Managers, Nursing Team

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| F 282 | <p>Continued From page 117</p> <p>Leaders and Nursing Management. Per interview, each had a group of residents they assessed and any injuries of unknown source were to be looked into. She reported however, there were no injuries of unknown source observed during the skin assessment audits. The DON indicated she and the Administrator reviewed the skin assessment audits, and the audits were taken by her to the QA meeting on 12/22/14. She revealed the skin assessment audits would continue weekly.</p> <p>Review of the QA Meeting sign-in sheet revealed there was a meeting dated 12/22/14 with all Department Heads present.</p> <p>4. Review of the statement, signed by the Corporate Nurse, dated 12/22/14, revealed on 12/18/14 she activated a Routine Behavior Monitor for Point of Care, the facility's electronic charting system, and an as needed option for every resident at the facility. Review of Resident #1's Kardex/Nurse Aide Care Plan revealed it was revised to reflect the resident's behavior/mood and included revised interventions for CNAs to assist with resident's care regarding behaviors.</p> <p>Review of the Performance Improvement (PI) Worksheet audit, revealed all residents' with behaviors were assessed for the Kardex being current with appropriate interventions for residents, and if the answer was no, the Kardex was updated.</p> <p>Review of the audit of residents with assessed behaviors, dated 12/19/14, revealed all their care plans were reviewed to ensure Behavior Comprehensive Care Plans were in place.</p> | F 282 | |

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| F 282 | <p>Continued From page 118</p> <p>Interview with the RN/MDS/RAI Coordinator, on 12/24/14 at 9:31 AM, revealed she had worked with the Corporate Nurse to ensure residents' behavior care plans would flow to the CNAs' Kardex on the facility's electronic charting system. She stated she reviewed all the residents' care plans and updated as needed.</p> <p>5. Review of the facility's PI Worksheets revealed on 12/19/14 and 12/20/14, files pertaining to abuse and self-reports were reviewed for the past thirty (30) days by the Administrator or Corporate staff. Resident #1's and Unsampled Resident C's investigations were reviewed with the following areas addressed: evidence of allegation; safe/secure resident-immediate report to DON/Administrator; alleged perpetrator removal; required initial notifications within time frame; staff was interviewed; Residents were interviewed; Social Service Assessments were completed; and education performed. On 12/21/14, any additional files which were generated from the auditing process were reviewed for the same information.</p> <p>Review of CNA #1's personnel file revealed she was terminated on 11/28/14.</p> <p>Interview with the CCO, on 12/24/14 at 11:14 AM, revealed when looking at the investigation related to the alleged abuse of Resident #1, he knew it was not good when CNA #1 completed her shift caring for residents, after the alleged abuse. He revealed staff should have reported the incident immediately. The CCO stated management reviewed Resident #1's investigation and agreed with the findings CNA #2 should have reported the witnessed incident of alleged abuse on</p> | F 282 | | |
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11/25/14 immediately after it occurred. Continued interview revealed they further looked over the investigation to see where the facility failed.

6. Review of the facility's PI Worksheet, dated 12/19/14 from 12:00 PM to 5:00 PM, revealed the Medical Records Director and the Business Office Coordinator audited 100% of the facility staff's personnel files. Continued review revealed the personnel files were checked for current license verification, Abuse Registry Check Registration, Criminal Background Check, and Kentucky Caregiver Misconduct Registry check. All personnel files were found to be 100% compliant.

Review of three (3) personnel files for employees, CNA #11, LPN #9, and the Social Worker revealed the files contained the audited documentation indicating compliance.

Interview with the Business Office Coordinator, on 12/23/14 at 3:19 PM, revealed she audited current facility staffs' personnel files to make sure they had the necessary documentation for compliance. She stated her findings were reported to the Administrator on 12/19/14, and to the QA Committee on 12/22/14. Continued interview revealed for new hires the background checks were done prior to the employee coming into the building.

Interview with the Administrator, on 12/24/14 at 10:23 AM, revealed for preventing abuse the process began with pre-employment screening. He reported staffs' personnel files had to be 100% compliant in the areas of Abuse, Criminal Background Checks, and with the Kentucky Caregiver Misconduct Registry. The

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| F 282 | Continued From page 120 Administrator reported he reviewed the results of the audits completed by the Business Office, and would continue to review newly hired staffs' files to ensure they were compliant with the required documentation. 7. Review of the facility's Abuse/Neglect/Misappropriation of Property policy revealed the policy was revised December 2014, for incidents involving residents, to indicate staff must "immediately report the incident to a supervisor on duty". Interview with the Administrator and DON, on 12/24/14 at 10:23 AM, revealed on 12/19/14, the CCO met with the Administrator, DON, Medical Director, the Nursing Leadership Team, and other Corporate Staff to discuss the identified concerns and the facility's abuse policy, to address the concerns identified. Per interview, they came up with a plan to educate the staff, and also discussed prevention and how the facility got to "this" point. 8. Review of the In-Services, dated 12/19/14 and 12/21/14, revealed the CCO and CRM educated the Administrator, DON, ADON, Unit Managers and Department Heads regarding the results of survey, the federal regulations and interpretive guidelines for tags, F223, F225, and F226, the facility's root cause analysis of the deficient practice and the newly revised abuse policy. Review revealed Department Heads were inserviced in a "Train the Trainer" manner regarding "Team Member" education covering abuse prevention, abuse reporting, investigations, Comprehensive Care Plans, the Kardex and the newly revised abuse policy. | F 282 | | | |

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Interview on 12/23/14 with: the Business Office Coordinator at 3:19 PM; Social Service Assistant/Activity Director #1 at 5:20 PM; and the RD at 6:06 PM; and on 12/24/14 with the Social Services Director at 10:05 AM revealed they were all inserviced on 12/19/14 and 12/22/14 in the "Train the Trainer" fashion as per the AOC. They all stated they were then able to inservice other staff. Per interview, they had to receive a score of 100% to pass the post-test.

Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed the CCO and CRM had trained them and all the Department Heads on 12/19/14 and 12/21/14, on abuse prevention, abuse reporting, investigations, Comprehensive Care Plans, the Kardex and the newly revised abuse policy Abuse in a "Train the Trainer" fashion, on 12/19/14. Per interview, all who were educated were required to achieve a 100% passing score on the post-test and had done so. Continued interview revealed the main changes to the abuse policy was to provide the term "immediately", which staff was educated on not to assume someone else reported the alleged abuse. They stated a question and answer session was performed after the education on 12/21/14, to determine the education was effective.

Interview with the CCO, on 12/24/14 at 11:14 AM, revealed he had looked at what the facility "failed" to do or where the facility had "failed" and addressed that through educating the Department Heads in a "Train the Trainer" fashion.

9. Review of the Inservice sign-in sheets dated 12/19/14 through 12/22/14, revealed staff was educated on abuse prevention, abuse reporting,

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| F 282 | <p>Continued From page 122</p> <p>investigations, Comprehensive Care Plans, the Kardex, the newly revised abuse policy and ensuring concerns were "immediately" reported. Review of the post-tests revealed staff achieved 100%.</p> <p>Interview on 12/23/14 with: CNA #2 at 9:22 AM; CNA #14 on 12/23/14 at 3:51 PM; Occupational Therapist (OT) #1 at 4:38 PM; Dietary Aide #1 at 4:54 PM; Laundry Assistant #1 at 5:05 PM; Activity and Social Services Assistant #1 at 5:20 PM; RN #3 at 5:38 PM; CNA #4 at 6:59 PM; CNA #16 at 7:12 PM; CNA #13 at 7:24 PM; LPN #8 at 7:33 PM; RN #5 at 7:48 PM; and on 12/24/14 with: RN #4 at 8:25 AM; CNA #8 at 8:58 AM; CNA #12 at 9:05 AM; CNA #17 at 9:27 AM; and, CNA #15 at 4:06 PM revealed they all were recently inserviced by a Department Head or Supervisor. They all reported the inservice was regarding the revised abuse policy, abuse prevention, investigations, and care plans related to the "Kardex". Per interview, the policy was accessible and could be found behind the nurse's station and in the break room. Staff stated the revised abuse policy stated to immediately report concerns to a supervisor as soon as the alleged abuse was observed. Continued interview with CNAs revealed they were familiar with the revision to their "Kardex" in which resident's behavior/mood was added. Dietary Aide #1 and Laundry Assistant #1 revealed they were not inserviced on the care plans/Kardex because they do not work directly with residents. All staff revealed they were given a post-test and had to have a passing score of 100%. Continued interview with staff revealed they continued to be questioned by management regarding the abuse policy, and CNAs stated they were being questioned regarding whether they had their</p> | F 282 | | |
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| F 282 | <p>Continued From page 123 residents' Kardex on their person or not.</p> <p>Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed no staff was allowed to work until they had received the required education. Per interview, all newly hired staff would receive the education prior to working in the facility through the interactive computer program which the Business Office Coordinator would track for completion. They stated the Business Office Coordinator would also monitor the annual mandatory abuse inservice education. Continued interview revealed staff would receive the "impromptu" education as necessary.</p> <p>10. Review of the "Team Member Abuse Policy Audit" forms revealed staff were randomly being selected to answer questions related to abuse.</p> <p>Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed twenty (20) staff was being interviewed and observed daily to determine their knowledge of the revised abuse policy and ensure they were knowledgeable of abuse prevention, reporting, investigation, how to locate the policy and knew to report immediately to one (1) of them in person or per the phone. They reported the revised abuse policy had been placed in break rooms and nurse's stations for staff's accessibility.</p> <p>Interview with the CCO, on 12/24/14 at 11:14 AM, revealed he along with upper management educated staff, up to twenty (20) a day and questioned them regarding the abuse policy. Continued interview with the CCO revealed an audit tool was being used, and an "Employee Roster" was checked with staff who were inserviced to ensure all staff was educated.</p> | F 282 | | |

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| F 282 | <p>Continued From page 124</p> <p>11. Review of the QA Committee sign-in sheet, dated 12/19/14 and 12/22/14 revealed the Medical Director, DON, Administrator, and other Department Heads signed the Sign-in Sheet. The agenda revealed they were scheduled to meet weekly for the next eight (8) weeks. Review revealed they discussed the survey results and the four (4) Immediate Jeopardy (IJ) tags, F223, F225, F226 and F282. Continued review revealed they discussed QA audits to be implemented, which included personnel files, review of facility investigations in the last thirty (30) days, skin assessments of residents, psychosocial assessments of residents, staff interviews/assessments, staff training, and staff implementation of residents' Comprehensive Care Plan and Kardex. The facility's abuse policy and procedure was also reviewed, and the reporting system reviewed.</p> <p>Interview with the Administrator on 12/23/14 at approximately 2:40 PM, revealed the QA Committee met to discuss the deficiencies on 12/19/14 and 12/22/14. He reported they discussed the results of the survey and compliance through the audits to be implemented, such as in-servicing staff, reviewing personnel files, review of facility investigations in the last thirty (30) days, skin assessments of residents, psychosocial assessments of residents, staff interviews/assessments, staff training, and staff implementation of residents' Comprehensive Care Plan and Kardex. The Administrator indicated the facility's abuse policy and procedure was also reviewed.</p> <p>12. Review of the Inservice education from 12/19/14 through 12/22/14, revealed nursing staff</p> | F 282 | | |
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| F 282 | Continued From page 125 and the IDT was provided education regarding residents' Comprehensive Care Plans and Kardex to ensure they were updated as necessary and staff implemented the residents' interventions. Continued review revealed the education was provided by the DON, ADON, Corporate RN, RN Managers and/or Team Lead Nurses. Interview, on 12/23/14 at 5:38 PM with RN #3, a Unit Manager, revealed she was part of the Nursing Leadership Team, and had assisted with providing the education to nursing staff and the IDT from 12/19/14 through 12/22/14. Interview on 12/23/14 with: OT #1 at 4:38 PM; LPN #8 at 7:33 PM; RN #5 at 7:48 PM; and, on 12/24/14 with RN #4 at 8:25 AM revealed they all had received the education provided from 12/19/14 through 12/22/14. Per interviews, the education included information regarding residents' Comprehensive Care Plans, the Kardex and ensuring these were updated and ensuring staff implemented the interventions. Interview with the Administrator and DON on 12/24/14 at 10:23 AM, revealed the education had been provided as per the AOC. 13. Review of the audits of residents' care plans for behavior from 12/19/14 through 12/22/14 revealed they were performed by the RN/MDS/RAI Coordinator, MDS Licensed Nurses, the Corporate RN and/or Social Services Director. Review revealed the care plans were updated as necessary. Review of the Inservice Attendance Sheet, dated 12/19/14 and ongoing, revealed staff signatures | F 282 | | |
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| F 282 | <p>Continued From page 126</p> <p>indicating they had received the Care Planning education.</p> <p>Review of the facility's PI Worksheet audit for the Kardex, revealed staff were being observed and interviewed regarding the following: CNAs had their residents' Kardex on their person; and CNAs knew how to use the Kardex.</p> <p>Interview on 12/23/14 with: CNA #2 at 9:22 AM; CNA #14 on 12/23/14 at 3:51 PM; CNA #4 at 6:59 PM; CNA #16 at 7:12 PM; CNA #13 at 7:24 PM; and on 12/24/14 with: CNA #8 at 8:58 AM; CNA #12 at 9:05 AM; CNA #17 at 9:27 AM; CNA #15 at 4:05 PM revealed they all were recently inserviced on care plans related to the "Kardex". Per interview, they were familiar with the revision to their "Kardex" in which resident's behavior/mood was added. Continued interview revealed they continued to be questioned by management regarding whether they had their residents' Kardex on their person or not.</p> <p>Interview with the RN/MDS/RAI Coordinator on 12/24/14 at 9:31 AM, revealed she had trained staff on how to track and monitor resident's behavior and informed them of the additional behavior plan added to the Kardex. She revealed CNAs were informed to advise nursing staff if there were any changes in the resident's behavior and how to document the behavior in the facility's computerized charting system. Per interview, she looked through residents' care plans the first time, then the DON and Unit Managers checked the resident's care plans and Social Services looked through them as well to ensure appropriate interventions were in place.</p> <p>Interview with the Administrator and DON, on</p> | F 282 | | |
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| F 282 | Continued From page 127 12/24/14 at 10:23 AM, revealed the CNAs' Kardex was being reviewed daily and updated as needed. They further revealed that CNAs were providing input other staff might not be aware of regarding a resident's behavior. Per interview, rounds were being performed by them, the Unit Managers, Team Lead Nurses and/or Clinical Department Heads to interview and observe CNAs to ensure they had their residents' Kardex on their person and were knowledgeable of the Kardex and the resident's interventions. According to the DON, the results of the observations and interviews were to be reported to her. The DON revealed staff was inserviced on residents' care plans and Kardex's and were informed the care plan directed each resident's plan of care. She stated CNAs were educated on residents' Behavior/Mood being added to the Kardex and the Interventions on how to deal with the resident's behaviors. She revealed the Kardex's were to be reviewed and revised as necessary, and printed out for the CNAs. | F 282 | | |

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| F 000 | Continued From page 1 yelling at them and being "rough" with them. However, staff had not reported the potential abuse per the facility's policy and procedures. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 12/23/14 with the facility alleging removal of the Immediate Jeopardy on 12/23/14. The Immediate Jeopardy was verified to be removed on 12/23/14 as alleged with remaining non-compliance in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225 and F-226 and 42 CFR 483.20 Resident Assessment, F-282 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes. | F 000 | <i>Without admitting or denying the validity or existence of the alleged deficiencies, including but not limited to any determinations of scope or severity, Villaspring provides the following plan of correction. This plan of correction is submitted as required by the state and federal guidelines and is not an admission or agreement with any of the cited information. This plan of correction is not meant to establish any standard of care, contract, obligation or position and Villaspring reserves all right to raise all possible contention and defenses in any civil or criminal claim action or proceeding. THIS PLAN OF CORRECTION SERVES AS Villaspring of Erlanger CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF 1/12/15.</i> | |
| 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Incident Reports/Investigation documents, Resident Rights document and facility policy and procedures, it was determined the facility failed to have an effective system to ensure each resident remained free from abuse | F 223 | F223 1. Resident #1 was assessed by the Director of Nursing (DON) on 11/26/14 about occurrence in shower. Registered Nurse (RN) performed full skin assessment on 11/26/14 with no findings related to the occurrence of 11/25/14. Licensed Social Worker on 11/26/14 and 12/18/14 assessed and has provided support to resident who has voiced no concerns with the staff/shower incident that occurred and has had no concerns of any other staff member abuse. Minimum Data Set (MDS) nurse completed comprehensive assessment of resident on 12/19/14 and noted no concerns, nor any difficulties with late effects of occurrence of 11/25/14. Comprehensive Care Plans and Kardcx (Nurse Aide Care Plan), verified on 12/20/14 by DON, reflect individualized approaches to manage behaviors. | |

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for one (1) of three (3) sampled residents (Resident #1).

On 11/25/14 between 3:30 PM and 4:00 PM, Certified Nursing Assistant (CNA) #1 was assisting Resident #1 with his/her shower, and was observed by CNA #2 and Nurse Aide in Training (NAT) #1 to intentionally spray the resident in the face with hot and cold water. Although, both staff observed the alleged abuse, neither staff reported it immediately. Therefore, CNA #1 continued working caring for Resident #1 and other residents on the unit. At approximately 6:00 PM, NAT #1 told CNA #4 about the alleged abuse of Resident #1 in the shower, and CNA #4 reported the incident to Licensed Practical Nurse (LPN) #1. LPN #1 informed the Director of Nursing (DON) and CNA #1 was removed from resident care, interviewed and escorted to clock out from work at 7:05 PM, approximately three (3) to three and a half (3.5) hours after the incident occurred.

The facility's failure to ensure an effective system in place to ensure each resident remained free from abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/18/14, and determined to exist on 11/25/14. The facility was notified of the Immediate Jeopardy on 12/18/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/23/14, with the facility alleging removal of the Immediate Jeopardy on 12/23/14. The Immediate Jeopardy was verified to be removed on 12/23/14, as alleged, with remaining non-compliance in the area of 42 CFR 483.13 Resident Behavior and Facility Practice, F 223 at a Scope and Severity of

F 223

Resident resides at facility, visited often by wife, assessed by licensed nursing staff and social worker to be safe and secure.

Alleged Team Member was terminated on 11/28/14 after investigation.

2. On 12/19/14, each cognitively intact resident with a Brief Interview of Mental Status (BIMS) >= 8 was interviewed by the Social Worker, Registered Dietician, Activity Director and/or Director of Rehabilitation to observation and interview for resident concerns of any potential abuse, neglect or misappropriation. Any allegation/concern was immediately followed up with by the Administrator; investigations completed as well as notifications, if indicated, were made by the Administrator.

On 12/18-19/14, Licensed nursing staff conducted head to toe assessments of each cognitively impaired resident (BIMS < 8 or non-interviewable) for any new/unusual bruises, skin tears etc., or other signs of potential abuse. There were no findings that would trigger an allegation of abuse. Results were reviewed by the Director of Nursing and

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a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's policy titled, "Abuse/Neglect/Misappropriation of Property", revised October 2014, revealed the definition of "abuse" was the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. "Physical abuse" was defined to include controlling behavior through corporal punishment.

Review of the facility's "Nursing Home Residents Bill of Rights and Responsibilities", undated, revealed all residents would be free from mental and physical abuse.

Review of the facility's "Self-Reported Incident Form, Initial Report" dated 11/25/14, completed by the DON, revealed a staff member reported CNA #1 sprayed Resident #1 "in the face with water" while giving the resident a shower. Per the Initial Report, Resident #1 was alert and oriented with occasional forgetfulness/confusion, and the resident was assessed with no signs or symptoms of injury noted. Further review of the Initial Report revealed CNA #1 was "sent home and removed from the schedule pending investigation".

Review of the facility's "Self-Reported Incident Form, 5 Day Follow-up/Final Report" document, dated 11/28/14, revealed CNA #1 was "clocked out" after two (2) other staff members "reported the issue". Per the 5 Day Follow-up/Final Report

F 223 Administrator.

On 12/19/14 all personnel files were audited by the Business Officer Coordinator and Medical Records Director for completion of pre-hire components used by the facility as part of screening and prevention of abuse. Files were 100% compliant.

3. Facility Abuse/Neglect/Misappropriation of Property policy was revised on 12/19/14 by Chief Operating Officer (COO), Corporate Risk Management (CRM), and Corporate Compliance Officer (CCO). (See Attached as Exhibit A)

On 12/19/2014-12/22/14 all staff (licensed nurses, certified nurse aides, licensed therapy staff, social service, activity, dietary, housekeeping, business office and maintenance) was provided in-service education by the Corporate Compliance Officer, Administrator, DON or Trained Trainer Department Head which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and reporting concerns immediately. Evidence of learning measured via written post-test; 100% accuracy required.

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document, CNA #1 and two (2) other "witnesses" submitted statements regarding the incident. The two (2) "witnesses" had the "same general statement" that CNA #1 "intentionally" sprayed water in Resident #1's face. Further review revealed nursing performed a skin assessment of Resident #1 with "no ill effects from the water being sprayed" in his/her face. Per the report, the Administrator and DON met with the two (2) witnesses (NAT #1 and CNA #2) again and both "felt" CNA #1 "intentionally sprayed" Resident #1 in the face. CNA #1 was terminated "upon final investigation on 11/28/14".

Record review revealed the facility admitted Resident #1 on 01/21/13, with diagnoses which included Depressive Disorder, Insomnia, and Osteoarthritis. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 10/21/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven (11) which indicated moderate cognitive impairment.

Review of Resident #1's statement, documented by the Social Worker (SW), dated 11/26/14, revealed the resident reported to the SW that two (2) aides, one (1) male and one (1) female took him/her to the shower room for his/her scheduled shower. Per the statement, Resident #1 reported the aide took the shower head and sprayed him/her "directly" in the face. Review revealed when Resident #1 asked her (the aide) to stop, the resident reported the female aide laughed at him/her and continued to spray him/her. Further review revealed once "she stopped", the aide proceeded with the shower and then returned Resident #1 to his/her room.

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On 12/19-22/14 all staff (licensed nurses, certified nurse aides, licensed therapy staff, social service, activity, dietary, housekeeping, business office and maintenance) was provided in-service education, the Team Member Education, by the Corporate Compliance Officer, Administrator, DON or Trained Trainer Department Head which covered Abuse Prevention, Abuse Reporting, Investigations, Comprehensive Care Plans, Kardex (Nurse Aide Care Plans) and reporting concerns immediately. Evidence of learning measured via written post-test; 100% accuracy required.

On 12/21/14 the Corporate Risk Manager and Corporate Compliance Officer each provided additional education to the Administrator, Director of Nursing, and Nursing Leadership Team on (1) review of federal regulations and interpretive guidelines of F223, F225, F226; (2) additional review of revision of Facility Policy on Abuse/Neglect/Misappropriation of Property; (3) root cause analysis of survey findings related to systematic response to allegations. Evidence of learning measured via meaningful Question and Answer) Q&A and discussion of case

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Interview with Resident #1 on 12/17/14 at 4:58 PM, revealed he/she recalled the shower incident on 11/25/14. Resident #1 stated CNA #1 was spraying him/her in the face with "ice cold" water with a shower hose. Per interview, CNA #1 said something "not nice" to him/her during the shower which made him/her "feel bad"; however, he/she could not recall what was said. Resident #1 stated he/she told CNA #1 he/she would not put up with that "shit", and he/she fought back. According to Resident #1, the shower incident made him feel "terrible", and he/she believed he/she told the "head nurse" about the incident, but was not certain of the nurse's name.

Review of CNA #2's written statement dated 11/25/14 at 6:15 PM, revealed CNA #1 "intentionally" sprayed Resident #1 in the face with water from the shower hose. Continued review of the statement revealed the incident/alleged abuse occurred on 11/25/14 at "4:30ish" PM. CNA #2 revealed CNA #1 was giving Resident #1 a shower and she was assisting as the resident sometimes had behaviors. CNA #2 reported CNA #1 was not paying attention and accidentally sprayed Resident #1 in the face again. The resident then started to call her names and swung his/her fist at her so she sprayed him/her in the face again. CNA #2 reported CNA #1 did this until the shower was finished.

Interview with CNA #2 on 12/16/14 at 5:25 PM and on 12/17/14 at approximately 3:30 PM, revealed she worked the 3:00 PM to 11:00 PM shift, and had worked on 11/25/14. She stated on 11/25/14, she was assisting CNA #1 in giving Resident #1 his/her shower, and the resident was agitated prior to the shower. Per interview,

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examples and a repeat verbalization of understanding of definitions and the facility system.

Any staff member who has not been at work or on leave or on vacation will complete all education and training prior to working their shift. No staff member will work without first being in-serviced. All newly hired staff members will be provided in-service education on abuse prevention, identification and reporting during their orientation prior to working in the facility through the interactive computer program with post-test and review of Abuse policy with signed verification. The Business Office Coordinator will track completion.

No agency use at the facility.

The Business Office Coordinator and Administrator will review each new hire personnel file to assure verifications and background checks are completed prior to beginning work.

Annual mandatory in-service of Abuse, including but not limited to prevention, will continue to be monitored by the Business Office Coordinator; additionally as indicated by concerns or observations, impromptu in-services for staff will be held as

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Resident #1 called CNA #1 a "nasty name", and CNA #1 then turned the shower water on cold. CNA #2 stated Resident #1 yelled, "stop, I don't like that....it's cold". According to CNA #2, NAT #1 told CNA #1 "that was not okay", and then left the shower room. CNA #2 revealed Registered Nurse (RN) #1, who was her immediate supervisor, completed a skin assessment on Resident #1 after the shower was completed, sometime between 3:30 PM to 4:30 PM. She revealed even though she thought the incident was abusive she did not report it to her supervisor, RN #1, because she was "non-confrontational". She stated she later realized she should have reported it. CNA #2 reported Resident #1 was taken back to his/her room where she remained with the resident while CNA #1 continued to answer call lights on the unit.

Review of CNA #1's written statement dated 11/25/14 at 6:59 PM, revealed the alleged abuse occurred on 11/25/14 at 4:00 PM. Per CNA #1's written statement Resident #1 was yelling and hitting her and grabbed at the shower head continually causing it to fall and get everything wet. Continued review of the statement revealed CNA #1 and CNA #2 washed Resident #1, rinsed him/her and the "skin nurse" (RN #1) performed a routine skin assessment. Continued review of the statement revealed that once the resident was washed and rinsed off me, CNA #2, and the skin nurse (RN #1) dried him/her off, put on his/her clothes and assisted him/her back to his/her wheelchair. After that, he/she was pushed to in the hallway by CNA #2.

Interview with CNA #1, on 12/17/14 at 2:35 PM revealed on 11/25/14 she had given Resident #1

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decided by the Administrator, DON and/or Ombudsman.

4. A Quality Assurance (QA) meeting was held on 12/19/14 with the Medial Director, Director of Nursing, Administrator and other members of the Quality Assurance Committee, who are the Resident Assessment Instrument (RAI) Coordinator and Department Heads (Social Services, Licensed Dietician, Chef, Maintenance Director, Activities Director, Medical Records Director, Business Office Coordinator, Housekeeping Supervisor, RN Unit Managers). The findings of the state survey as well as deficiencies, including scope and severity, were discussed. Action plans to address each deficiency as well as the overall system were developed and approved by the QA Committee. On 12/22/14 a second full Quality Assurance meeting was held to review the action plans to remove immediate jeopardy. Findings of all observations and interviews, compliance with in-servicing and results of monitoring were analyzed and discussed. Findings will be reported by the DON, Administrator or Social Services Director and followed by each with Committee recommendations. QA Committee recommends Allegation of Compliance (AOC) - removal of

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F 223. Continued From page 7
a shower; however, was not certain of the time. She revealed Resident #1 becomes combative when being given a shower, and was combative that day when staff put him/her into the wheelchair to take him/her to the shower room. CNA #1 revealed she asked NAT #1 to assist her with putting Resident #1 in the shower chair. She stated the water in the shower room was always too hot or too cold. Per interview, as she was giving Resident #1 his/her shower water got all over her and NAT #1 thought it was funny. She stated NAT #1 then gave Resident #1 the shower head and the resident started spraying her. Continued interview revealed she told NAT #1 to leave the shower room because he was not being helpful. CNA #1 revealed after Resident #1's shower, RN #1 assessed his/her skin, and then she and CNA #2 assisted the resident in getting dressed and pushed him/her to the dining area for dinner. CNA #1 reported she was assigned to work with CNA #2 on the same hall that day. CNA #1 revealed she worked from 11:00 AM to 7:00 PM on 11/25/14, and was not aware there was a concern regarding her care of Resident #1 until the DON approached her when she was getting ready to leave for the day. She stated she thought it was "almost 7:00 PM" when this happened, and the DON told her a report had been made against her. According to CNA #1, the DON had her write a statement concerning the allegations, and she did not return to work as she was terminated on 11/28/14.

Review of CNA #1's timecard revealed on 11/25/14: she clocked in to work at 10:56 AM; clocked out at 3:17 PM; clocked back in at 3:47 PM; clocked out from work at 7:05 PM.

Review of Registered Nurse (RN) #1's written

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immediate jeopardy date by 12/23/14.

Audits began on 12/20/14 with observation and interview of staff members, while staff are performing their respective direct care job duties/responsibilities, by Administrator, DON, RN Nurse Managers, and other Department Heads to ensure deficient practice does not occur. Observation and interview designed to detect if staff members are knowledgeable about prevention, reporting, investigation of abuse and know how to locate and review the revised abuse policy. Facility will perform interviews of at least 20 staff members weekly, across different shifts and on weekends, until Substantial Compliance is obtained. After Substantial Compliance is obtained, the QA team will determine the frequency of the staff interviews. (See Attached as Exhibit B)

Licensed nursing staff will continue to conduct weekly head to toe assessments of each cognitively impaired resident (BIMS < 8 or non-interviewable) for any new/unusual bruises, skin tears etc., or other signs of potential abuse.

Social services department will interview residents with BIMS

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| F 223 | Continued From page 8 statement dated 11/26/14 at 1:00 PM, revealed the alleged abuse occurred on 11/25/14 at approximately 4:30 PM. Review revealed RN #1 spoke with Resident #1 regarding the shower he/she received on 11/25/14, and the resident reported it was "terrible". Continued review revealed Resident #1 told RN #1 the aide giving him/her the shower, squirted him/her in the face with the water hose, then laughed after doing so. Per RN #1's written statement, Resident #1 stated there were three (3) aides assisting him/her with the shower, but did not know their names. Interview with RN #1, on 12/16/14 at 4:27 PM, revealed she worked 11/25/14 until about 5:30 or 6:00 PM. RN #1 stated she conducted a routine skin assessment of Resident #1 after his/her shower that day. Per interview, CNA #1 and CNA #2 were in the shower room with Resident #1 when she entered to perform the routine skin assessment. RN #1 stated CNA #2 did not report the alleged abusive incident to her that day, and neither did NAT #1. She stated she was not aware of the shower incident until the next day, 11/26/14, when it was requested she conduct another skin assessment on Resident #1 to ensure he/she was free from any bruising. Continued interview with RN #1 revealed she would have expected CNA #2 and NAT #1 to have reported the alleged abuse when they witnessed it. Review of NAT #1's written statement dated 11/25/14 at 7:15 PM, revealed the incident/alleged abuse occurred on 11/25/14 at 4:00 PM. Review revealed he felt Resident #1 was sprayed in the face with hot water by CNA #1 because he/she would not comply with her. Per | F 223 | greater than or equal to 8 for abuse, performing a minimum of 10 residents weekly and will report findings to QA team until Substantial Compliance is obtained. All negative statements will be reported to the Administrator and DON immediately. After Substantial Compliance is obtained, the QA team will determine the frequency of the staff interviews. (See Attached as Exhibit C) Each allegation of abuse will be reported immediately by the staff to the Director of Nursing or the Administrator. If the DON or administrator is not in the facility, they will contact the DON or Administrator via phone, which these numbers are posted in multiple different locations (the time clocks and nursing stations) for thorough/timely investigation and reporting. The Administrator is notified immediately of each allegation, across all shifts and weekends. The Interdisciplinary Team consists of Administrator, DON, Social Worker, Licensed Dietician, Chef, Maintenance Director, Activities Director, Medical Records Director, Business Office Coordinator, Housekeeping Supervisor, RN Unit Managers, and other Department Heads. The Interdisciplinary Team | | |

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 NAT #1's written statement, he heard Resident #1 scream, "stop spraying my face, you are burning me", and when he turned around CNA #1 was spraying the resident with hot water in the face. NAT #1's written statement revealed he heard CNA #1 tell Resident #1 to "stop fighting me and this wouldn't happen", and then CNA #1 turned the water in the shower to warm. Continued review revealed he told CNA #1 to not do that and to "be good" to Resident #1, and he gave the resident control of the shower. Per NAT #1's written statement, CNA #1 told him to "get the fuck out of here", and he left the shower room.

Interview, on 12/17/14 at 1:09 PM, with NAT #1 revealed he worked on 11/25/14, and was assigned on the rehabilitation (rehab) hall of the unit. He stated CNA #1 came and asked him to assist with getting Resident #1 into the shower, not too long after he clocked in around 3:00 PM. NAT #1 revealed he assisted with getting Resident #1 into the shower and stayed in the shower room to assist with transferring the resident back into the wheelchair after the shower. Per interview, CNA #1, CNA #2 and himself were in the room during the resident's shower, and he saw CNA #1 spraying water into Resident #1's face. NAT #1 reported he heard Resident #1 yell over and over again, "stop you're burning me". According to NAT #1, CNA #1 stated to Resident #1 if he/she "would just listen to" her, she "wouldn't have to do this." NAT #1 revealed he told CNA #1 to "stop" spraying Resident #1 in the face with the water, and CNA #1 stopped and told him to come and "do it" (shower the resident). The NAT stated he turned the water to a comfortable temperature which was not "so" hot, and handed the shower head to the resident to use. He stated CNA #1 then told

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 has daily "Stand Up" meetings on Monday – Friday lead by the Administrator and DON. These will be on-going. Any incident/grievances/requests, etc. are addressed as needed and reported to the IDT the following meeting day. If any incident/grievance occurs on the weekend, it will be discussed in the Monday morning meeting. Again, the Administrator is notified immediately of each allegation, across all shifts and including weekends. The corporate compliance officer or the chief operating officer is notified by the administrator of any allegations. The CCO or the COO will monitor the process of the investigation daily until the investigation is finalized. The CCO or the COO will ensure audit the investigation and allegations to ensure substantial compliance.

Corporate Compliance Officer and/or Corporate Risk Manager will perform a weekly observation and review of all facility investigations. This includes, but is not limited to, immediate removal of any alleged or perpetrating staff from the facility, immediate reporting to administrator, interview of resident and staff, assessment of alleged victim, root cause analysis, conclusion, and review of

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| F 223 | <p>Continued From page 10</p> <p>him to get the "fuck" out of the shower room. Continued interview revealed he told CNA #1 to "be good to Resident #1", and left the shower room to return to work on the rehab hall. Per interview, at "around 5:30 PM" he told CNA #4 what had occurred in the shower room, and she told him the incident was "unacceptable" and should be reported. He stated he went to lunch and when he returned to the unit CNA #4 had already reported the incident to the DON. NAT #1 stated he felt the shower room incident involving Resident #1 was abuse now; however, the facility had not given him much training on abuse prior to the incident.</p> <p>Review of CNA #4's written statement dated 11/25/14 at 6:59 PM, revealed the incident/alleged abuse occurred earlier that day at 4:00 PM. Review revealed NAT #1 told her another "team member" (CNA #1) sprayed hot water in Resident #1's face. Continued review revealed NAT #1 told her CNA #1 was giving Resident #1 a shower and sprayed water in the resident's face.</p> <p>Interview with CNA #4, on 12/17/14 at 11:20 AM, revealed NAT #1 came to her after she clocked in for work at about 5:30 PM to 5:45 PM. Per interview, NAT #1 told her what had occurred in the shower during Resident #1's shower. She stated NAT #1 told her CNA #1 squirted cold and hot water in Resident #1's face. CNA #4 she told NAT #1 "that was called abuse", and he needed to tell the nurse, LPN #1. Continued interview revealed NAT #1 told her he would tell the Administrator and left to go on his lunch break. She revealed she reported the incident to LPN #1 herself because she didn't want it on her "conscience". Additional interview with CNA #4</p> | F 223 | <p>investigation action meeting policy and federal requirements, results provided to QA Committee.</p> <p>The QA team consists of the Medical Director, DON, Administrator and Departments Heads, which meets weekly. All monitoring/auditing of verifying timely reporting of allegation/grievance/report results are reviewed by the QA Team with appropriate follow-up required as needed. QA meetings were held on the following dates: 12/19/14, 12/22/14, 12/23/14, 12/29/14, 1/5/15, 1/12/15, and 1/19/15. QA Committee meetings will continue weekly for 8 weeks and then the frequency will be determined by QA Committee with a minimum of quarterly.</p> <p>All monitoring findings will be reviewed at Quality Assurance Meetings that will take place weekly, until facility is in Substantial Compliance, when that occurs, the QA Committee will decide on frequency of meetings with a minimum of Quarterly, in order to keep facility in Substantial Compliance. QA team consists of Medical Director, DON, Administrator and Departments Heads.</p> <p>5. Date of Compliance: The facility</p> | | |

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revealed she had observed CNA #1 yell at a resident before which she thought was abusive; however, she did not report it, but should have.

Interview with LPN #1, on 12/16/14 at 5:43 PM, revealed she worked on 11/25/14, and thought CNA #4 reported the alleged abuse to her somewhere between 5:30 PM and 6:00 PM, when she was administering evening medications. Continued interview revealed CNA #4 told her NAT #1 was upset over observing CNA #1 spraying Resident #1 in the face with water from the shower hose. LPN #1 stated she went immediately and reported the incident to the DON. Per interview, the DON asked her if she had removed CNA #1 from resident care and she told the DON she had not. LPN #1 stated the DON pulled CNA #1 from resident care to discuss the allegations with her.

Interview with the DON on 12/18/14 at 1:00 PM, revealed on 11/25/14, LPN #1 came to her office "around 6ish", and reported NAT #1 told CNA #4 about an alleged abuse involving Resident #1 and CNA #4 had informed her. Per interview, LPN #1 stated CNA #4 told her she told NAT #1 he needed to report the alleged abuse incident to the DON. Continued interview revealed the DON removed CNA #1 from resident care, and asked her if she had given Resident #1 a shower earlier that day and if so, had anything unusual had happened. She stated CNA #1 denied intentionally spraying Resident #1 in the face with water during the shower. Per interview, she spoke to Resident #1 later on that day to ensure he/she was okay. According to the DON, in this case, CNA #2 stayed with Resident #1 to ensure his/her safety. She revealed however, she did not have an answer regarding how all other

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has continued to execute all audits, preventative measures, policy revisions and monitoring of performance developed via the AOC and POC process. Analysis of the whole, via QA meetings, indicates our system is working and substantial compliance alleged 1/12/15.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185447 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 12/29/2014 |
| NAME OF PROVIDER OR SUPPLIER VILLASPRING OF ERLANGER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 630 VIOX DRIVE ERLANGER, KY 41018 | | |
| (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 12 residents, receiving care from CNA #1, were protected from abuse. Interview with the Administrator, on 12/18/14 at approximately 2:06 PM, revealed the DON called him somewhere between 6:00 PM and 7:00 PM, after he had left the facility, and informed him of the alleged abuse. He stated on 11/26/14, he had CNA #1 come to his office to verify her statement and told her she was suspended pending the investigation results. Continued interview revealed he then followed up with NAT #1 and CNA #2, who both believed CNA #1's actions were intentional when she sprayed water in Resident #1's face. Per interview, CNA #1 was terminated on 11/28/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 12/23/14 which alleged removal of the IJ effective 12/23/14. Review of the AOC revealed the facility implemented the following: 1. Resident #1 was assessed by the DON on 11/26/14, regarding the occurrence in the shower. An RN performed a full skin assessment of Resident #1 on 11/26/14 with no findings related to the occurrence of 11/25/14. A Social Worker (SW) assessed Resident #1 on 11/26/14 and on 12/18/14 and provided support to the resident who voiced no concerns with the staff/shower incident and had no concerns of any other staff member abuse. A MDS Nurse completed a comprehensive assessment of Resident #1 on 12/19/14 and noted no concerns, nor any difficulties with late effects of the occurrence of 11/25/14. Resident #1's Comprehensive Care Plans and Kardex (CNA Care Plan), were verified on 12/20/14 by the DON to reflect individualized | F 223 | | | |