

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

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

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 223 Continued From page 13 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 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

F 223

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F 223 Continued From page 14
required action at the time.

F 223

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 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

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F 223	Continued From page 15 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 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	F 223			

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F 223	Continued From page 16 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 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	F 223			

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F 223: Continued From page 17

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.

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.

Also, besides being directly taught to staff, the revised policy was placed in areas staff/team members typically congregate, take breaks and eat lunch.

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

F 223

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F 223 Continued From page 18
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 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

F 223

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F 223 Continued From page 19
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 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

F 223

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F 223	Continued From page 20 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, 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	F 223			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 223	Continued From page 21 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. 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,	F 223			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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--------------------	--	---------------	---	----------------------

F 223: Continued From page 22

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, Unsampld Resident A and Unsampld 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 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

F 223

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--------------------	--	---------------	---	----------------------

F 223 Continued From page 23 on 12/22/14. F 223

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 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

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F 223	Continued From page 24 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 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. 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. 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. 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. 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	F 223			

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OMB NO. 0938-0391

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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
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F 223 Continued From page 25
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.

Review of CNA #1's personnel file revealed she was terminated on 11/28/14.

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.

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.

F 223

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

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

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
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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 223	<p>Continued From page 26</p> <p>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 documentation indicating compliance.</p> <p>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.</p> <p>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.</p> <p>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".</p>	F 223		
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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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			(X5) COMPLETION DATE

F 223 Continued From page 27

F 223

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.

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

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

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

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 223	Continued From page 28 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, 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	F 223			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188447	(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 223 Continued From page 29

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 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

F 223

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

PRINTED: 01/16/2015
FORM APPROVED
OMB NO. 0938-0391

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 30 the "promptu" 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. 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	F 223			

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

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

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
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--------------------	--	---------------	---	----------------------

F 223	<p>Continued From page 31</p> <p>(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 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.</p> <p>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</p>	F 223		
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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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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 223 : Continued From page 32
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.

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

F 223 :

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

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

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
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F 223	<p>Continued From page 33</p> <p>#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 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</p>	F 223			

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

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

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
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F 223	Continued From page 34 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 223	F225 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 225 SS-J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	2. On 12/19/14, the Facility Administrator, Corporate Compliance Officer and Risk Manager reviewed each file of		

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

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

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
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F 225 Continued From page 35

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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 after an allegation of abuse was immediately reported and a thorough investigation was conducted to include interviewing all interviewable residents on the unit, interviewing all staff working on the unit at the time of the allegation and ensuring assessment of all non-interviewable residents on the unit for one (1) of four (4) sampled residents (Resident #1).

On 11/25/14, Resident #1 was taken to the shower somewhere between 3:30 PM and 4:00 PM. Three (3) staff were 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 caring for Resident #1 and other residents on the unit. NAT #1 informed CNA #4 of what he had witnessed and CNA #4

F 225

resident allegation of abuse/self report of potential abuse in the past 30 days to assure completeness and thoroughness of investigation. On 12/20/14 any action required was taken by Administrator. On 12/21/14, the Facility Administrator, Corporate Compliance Officer and Risk Manager reviewed additional investigation files generated by whole house observations and interviews completed 12/19-20/14. Administrator took action, if any, as required.

On 12/19/14, each cognitively intact resident with a BIMS \geq 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.,

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

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

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)

F 225 Continued From page 36

reported the alleged abuse to Licensed Practical Nurse (LPN) 1, who then reported it to the Director of Nursing (DON). The DON initiated an investigation which included assessment of Resident #1 and interviews with the resident, NAT #1, CNA #2 and CNA #1. However, the facility's investigation did not include: assessment of all non-interviewable residents for potential harm or injuries of unknown origin; interviews with all interviewable residents; and interviews with all staff working on the unit at the time of the alleged abuse. CNA #1 was removed from resident care after the DON became aware of the alleged abuse. CNA #1 clocked out of work from the facility at 7:05 PM. (Refer to F223 and F226)

The facility's failure to ensure an effective system was in place to ensure a thorough investigation was conducted to include interviewing all interviewable residents on the unit, interviewing all staff working on the unit at the time of the allegation and ensuring assessment of all non-interviewable residents on the unit 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 at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality

F 225

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 and reported to the QA committee on 12/23/14.

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

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

On 12/19/14 the Corporate Compliance Officer inserviced 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 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) to ensure each staff member is in-serviced by

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

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

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
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F 225	<p>Continued From page 37</p> <p>Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse/Neglect/Misappropriation of Property", revised October 2014, revealed when an incident or occurrence had been identified as abuse, neglect or misappropriation and investigation would immediately follow. Review of the "Identification" section of the Policy revealed when a staff member suspected abuse had occurred against a resident they must report the incident to their immediate supervisor an investigation would be immediately initiated. The Policy revealed the investigation was to include interviews with all appropriate staff, residents, family or visitors who might have information concerning the incident. However, further review of the Policy revealed it did not address specific measures to ensure a thorough investigation was conducted, e.g. conducting physical assessments of all vulnerable non-interviewable residents.</p> <p>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.</p> <p>Review of the facility's "5 Day Follow-up/Final Report" form dated 11/28/14, 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, attached to the "5 Day Follow-up/Final Report" form, revealed Resident #1's statement</p>	F 225	<p>12/22/14. Evidence of learning measured via written post-test; 100% accuracy required.</p> <p>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.</p> <p>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.</p>		

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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F 225 | Continued From page 38

dated 11/26/14 at 10:03 AM, which noted the resident reported a female aide took the shower head and sprayed him/her directly in the face with water. Per Resident #1's statement, when he/she asked the female aide to stop, she laughed at him/her 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. In addition, the 5 Day Follow-up/Final Report form revealed 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. Per the 5 Day Follow up/Final Report CNA #1 was terminated "upon final investigation on 11/28/14".

However, further review of the facility's investigation of the incident on 11/25/14, involving Resident #1, revealed no documented evidence: all interviewable residents residing on the same unit on which Resident #1 resided were interviewed regarding CNA #1's care or possible knowledge of the alleged abuse; all staff working on the unit at the time of the alleged abuse were interviewed; and all non-interviewable residents were physically assessed for signs of possible abuse by the alleged perpetrator, CNA #1.

Interview, on 12/17/14 at 4:58 PM, with Resident #1 revealed on 11/25/14, the resident recalled CNA #1 spraying him/her in the face with "ice cold" water and he/she fought back. Resident #1

F 225

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.

No agency use at the facility.

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.

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

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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F 225: Continued From page 39
revealed the incident made him/her feel "terrible", and the resident thought he/she reported the incident to the head nurse; however, could not recall her name.

Interview, on 12/16/14 at 5:25 PM and on 12/17/14 at approximately 3:30 PM, with CNA #2 revealed on 11/25/14 around 3:00 PM to 3:30 PM, she was assisting CNA #1 with giving Resident #1 a shower. She stated Resident #1 was agitated before the shower and during the shower the resident called CNA #1 a "nasty" name. CNA #2 revealed CNA #1 turned the water on cold, sprayed Resident #1 in the face and the resident yelled, "stop, I don't like that...it's cold". Per interview, CNA #2 revealed even though she thought the incident was abusive, she did not report the incident as she was "non-confrontational". Continued interview revealed she realized later she should have reported the incident as possible abuse.

Interview, on 12/17/14 at 1:09 PM, with NAT #1 revealed around 3:00 PM on 11/25/14, during the shower he heard Resident #1 yell over and over again, "stop you're burning me", and reported he saw CNA #1 spraying water into the resident's face. NAT #1 revealed CNA #1 told Resident #1 "if you would just listen to me, I wouldn't have to do this." According to NAT #1, he went back to work on his hall and did not tell anyone what he had witnessed until around 5:30 PM, when he told CNA #4. NAT #1 stated CNA #4 told him the incident involving Resident #1 was "unacceptable" and should have been reported; however he stated he clocked out and went to lunch. The NAT reported he had previously observed CNA #1 being a little "rough" with residents, being a "bit aggressive" with getting

F 225 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 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 Committee recommends Allegation of Compliance – removal of immediate jeopardy date by 12/23/14.

Each allegation of abuse will be reported immediately by the staff to the Director of Nursing or the Administrator. If the DON or

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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F 225 Continued From page 40
residents to roll over and had heard CNA #1 yell at residents. He stated he thought these behaviors could be abusive and stated he would never have talked to a resident the way CNA #1 did. However, NAT #1 indicated he had never reported CNA #1 behaviors to his supervisor.

Interview with CNA #4, on 12/17/14 at 11:20 AM, revealed 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. She revealed she reported the incident to LPN #1 herself because she didn't want it on her "conscience". Additional interview with CNA #4 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 on 11/25/14, 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, but did not remove CNA #1 from resident care per the facility's policy and procedure. LPN #1 stated the DON pulled CNA #1 from resident care to discuss the allegations with her. Further interview with LPN #1 revealed NAT #1 was questioned regarding the allegations when he returned from his break. However, review of the facility's 5 Day Follow-up/Final Report and investigation documentation revealed no documented evidence LPN #1 was interviewed or gave a written statement regarding the alleged abuse.

Interview with Registered Nurse (RN) #1, on

F 225
administrator is not in the facility, they will contact the DON or Administrator via phone, which these numbers are posted in at least 3 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 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.

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

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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F 225 Continued From page 41

12/16/14 at 4:27 PM, revealed revealed neither NAT #1 or CNA #2 reported the incident/alleged abuse to her on 11/25/14 after the incident occurred. RN #1 reported she was not made aware of the alleged abuse of Resident #1 by CNA #1, until the next day. Further interview with RN #1 revealed she would have expected CNA #2 and/or NAT #1 to have reported the abuse to their supervisor after witnessing it.

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 reported she was suspended. Per interview, she was terminated on 11/28/14.

Interview, on 12/17/14 at 5:26 PM, with CNA #8 revealed she asked to work on a different hall of the unit when CNA #1 was working because she didn't like the way CNA #1 "talked to the residents". Per interview, CNA #1 was very "stern" with residents, never "really ever gave the residents an option" and was "kind of rough with them". She stated she had never witnessed physical abuse by CNA #1, but had heard of verbal abuse by CNA #1 from other CNAs, who included CNA #2 and CNA #6.

Interview, on 12/17/14 at 6:30 PM, with CNA #6 revealed she had worked on 11/25/14; however, had not been questioned by the DON about CNA #1's care of residents. Per interview, she had witnessed CNA #1 being verbally abusive "a couple of times" before that day. She stated CNA #1 would "yell" at Resident #1 and other residents, and she had reported this to the

F 225:

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)

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

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

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FORM APPROVED
OMB NO. 0938-0391

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
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--------------------	--	---------------	---	----------------------

F 225 Continued From page 42

nurses. CNA #6 stated the nurses she reported her allegations to included RN #2 and LPN #2. Per interview, the nurses reported her allegations of verbal abuse by CNA #1 towards residents to the DON; however, the DON didn't do anything about it. According to CNA #6, if the DON had done something about the alleged verbal abuse, the shower incident involving Resident #1 might not have occurred.

Interview, on 12/17/14 at 8:04 PM, with RN #2 revealed CNA #1 had a "bit of attitude", was "mouthy" and "confrontational" with the nurses. However, she stated she had never had any allegations of verbal or physical abuse by CNA #1 towards residents reported to her.

Interview, on 12/17/14 at 9:25 PM, with LPN #2 revealed nothing had been reported to her about CNA #1's behavior towards residents.

Interview with the DON on 12/18/14 at 1:00 PM, revealed no one had ever reported anything regarding allegations of verbal abuse or any other form of abuse of residents by CNA #1 to her until 11/25/14. Per interview, LPN #1 came to her office and reported NAT #1 had told CNA #4 about the shower incident involving Resident #1 and CNA #1. She reported she removed CNA #1 from resident care and questioned her about the shower incident, and had the CNA write a statement and had the CNA leave the facility. According to the DON, she talked to NAT #1 and CNA #2 later and asked them to provide written statements regarding the alleged abuse. She stated Resident #1 was assessed by RN #1 during the facility's "skin rounds" which occurred weekly. However, per interview all other non-interviewable residents were not physically

F 225

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.

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

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

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OMB NO. 0938-0391

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F 225 | Continued From page 43
assessed after she was informed of the alleged abuse on 11/25/14. The DON stated she believed all non-interviewable residents' should have been physically assessed after the incident thorough. She stated she interviewed some of the alert and oriented residents on the unit on 11/25/14, after the incident was reported to her. However, all interviewable residents were not interviewed until 11/26/14, when she asked the Social Worker (SW) to interview all alert and oriented residents which the SW determined as residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or above. The DON stated she had "informally" interviewed other staff working that night; however, she had not documented these interviews. The facility's investigation included no documented evidence of these interviews.

Interview, on 12/18/14 at 2:06 PM, with the Administrator revealed the DON notified him of the incident involving Resident #1 and CNA #1 on 11/25/14 "between 6:00 PM and 7:00 PM". Continued interview with the Administrator revealed he verified CNA #1's written statement with her on 11/26/14 when he had her come to the facility, and she told him she hadn't done what was reported. He stated he followed up with NAT #1 and CNA #2 regarding the incident and they felt CNA #1 had intentionally sprayed Resident #1 in the face with water. According to the Administrator, he supported what NAT #1 had done, because once the NAT thought the incident was abuse, he reported it. He stated "initially" NAT #1 did not think the shower incident was intentional on the part of CNA #1, but after he thought about it he reported it. However, per interview, the facility's expectation was if staff viewed an incident as abuse, then they should

F 225
with a minimum of Quarterly, in order to keep facility in Substantial Compliance. QA team consists of Medical Director, DON, Administrator and Departments 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.

1/12/15

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

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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
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F 225 Continued From page 44 F 225

report it as soon as possible. The Administrator revealed if NAT #1 and CNA #2 thought the incident was alleged abuse when it happened, they should have reported the incident, and once they felt the incident was potentially abuse they had reported it. According to the Administrator, staff should "report as soon as reasonably possible"; however, the facility's policy intent was for staff to report incidents involving possible abuse immediately. He stated all non-interviewable residents were physically assessed as it was "around the time of our skin rounds", but stated "not that night necessarily". However, no documented evidence was provided to ensure the skin assessments were performed on 11/25/14 after the alleged incident. Further interview revealed the SW interviewed all interviewable residents on 11/26/14. The Administrator stated the facility did what they were supposed to do related to this incident.

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

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

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OMB NO. 0938-0391

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 225	Continued From page 45 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 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	F 225			

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

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

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
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F 225 Continued From page 46 F 225

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 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

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

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OMB NO. 0938-0391

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F 225	<p>Continued From page 47</p> <p>was terminated on 11/28/14 after the completion of the facility's investigation.</p> <p>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.</p> <p>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.</p> <p>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</p>	F 225		

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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F 225	<p>Continued From page 48</p> <p>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.</p> <p>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.</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</p>	F 225		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 225: Continued From page 49

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.

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.

Also, besides being directly taught to staff, the revised policy was placed in areas staff/team members typically congregate, take breaks and eat lunch.

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

F 225

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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F 225	Continued From page 50 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 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	F 225			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 51 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 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	F 225			

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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F 225	<p>Continued From page 52</p> <p>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.</p> <p>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.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> 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 	F 225		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186447	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/29/2014
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F 225	<p>Continued From page 53</p> <p>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 12/18/14 and had been following up with the resident by reviewing his/her care plan.</p> <p>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.</p>	F 225		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 54</p> <p>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.</p> <p>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.</p> <p>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.</p>	F 225		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	Continued From page 55	F 225		
	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>			

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

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F 225 | Continued From page 56
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 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.

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.

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.

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.

5. Review of the facility's PI Worksheets

F 225

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

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

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 225 Continued From page 57

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 Unsamped 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.

Review of CNA #1's personnel file revealed she was terminated on 11/28/14.

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.

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

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F 225 | Continued From page 58

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 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

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F 225	Continued From page 59 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. 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	F 225			

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F 225 : Continued From page 60
score of 100% to pass the post-test.

F 225 :

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, 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

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F 225 Continued From page 61
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 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

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F 225	<p>Continued From page 62</p> <p>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> <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,</p>	F 225			