

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

PRINTED: 05/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2014
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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Administration was notified of the allegations. The DON revealed she had not obtained a written statement from SRNA #1. She stated SRNA #1 had been off work on 02/25/14, had been suspended on 02/26/14, and had not returned to work until 03/04/14. The DON stated the facility had not provided follow up abuse inservices or re-education for staff including SRNA #1 and SRNA #2 following the investigation.

Interview, on 03/05/14 at 7:15 PM and 03/08/14 at 4:30 PM, and 03/11/14 at 3:14 PM with the Administrator revealed the DON called him on 02/25/14, and stated she was informed SRNA #2 had been working with SRNA #1; and felt SRNA #1's language to the residents was inappropriate. According to the Administrator the DON felt SRNA #2's allegation rose to the level of abuse. Further interview revealed the DON informed him the allegation was made on 02/25/14; although the incidents had occurred five (5) days earlier, on 02/20/14. He stated he told the DON, she and the SS Director were to go ahead and attend a conference the next day; and he would look into the allegations the next morning. The Administrator stated SRNA #1 worked on 02/25/14, so he decided to wait for the DON to start the investigation when she returned to the facility on 02/26/14, since the perpetrator would not be working until the weekend. Continued interview revealed the DON and the SS Director did not return to the facility until 02/27/14, and this had "put them a day behind" with the investigation. He stated he was aware the facility had about twenty-four (24) hours to report allegations to the State Agencies; but his thinking was clouded because he felt it was not truly abuse. He indicated he thought it had all been due to a conflict with staff, between SRNA #1 and

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RN #1. The Administrator stated the investigation consisted only of talking to interviewable residents, including Resident #12 and #15 and Resident 1 (sister and roommate of Resident #1) on 02/27/14, and later interviews were obtained with other interviewable residents. He stated a written statement was not obtained from SRNA #1; however, it should have been as part of the facility's investigation. According to the Administrator, all the staff who worked the evening of 02/20/14 should have been interviewed and statements obtained. He indicated he felt the facility should have completed a more thorough investigation into the allegations made on 02/25/14; to have included the interviews with all staff involved and working that night. He stated SRNA #1 came to work on 02/26/14; however, he thought she had not been scheduled to work again until the weekend, and had not contacted her related to suspending her pending the investigation. The Administrator stated someone notified him SRNA #1 had been on the unit working on 02/26/14; and he stated he had her brought to the office and suspended her at that time. Continued interview and review of the "Combined Incident Report/Final Report" form with the Administrator revealed he had mistakenly indicated the incident date was 02/26/14; but it should have been 02/20/14. He stated he was unsure of why he left out the physical abuse of Resident #1 on the "Combined Incident Report/Final Report" which he submitted to the State Agencies on 02/28/14. The Administrator stated investigations of abuse were to be thoroughly investigated and reported timely. In addition, he stated the State Agencies should have been notified timely, the investigation should have been more thorough, and the alleged perpetrator should have been suspended pending

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investigation at the time Administration became aware of the allegation because there was the potential for harm of residents if the Abuse Policy was not followed.

The facility provided an acceptable credible Allegation of Compliance (AOC), on 03/12/14 which alleged removal of the Immediate Jeopardy on 03/07/14. Review of the AOC revealed the facility implemented the following:

1. The investigation was reopened on 03/05/14. Residents #12 and #15 were re-interviewed with additional questions by the DON, Administrator and/or Social Services (SS) Director on 03/06/14. Resident #1's roommate, which was the resident's sister was interviewed on 03/06/14, by the DON because Resident #1 was not interviewable. During the resident interviews on 03/06/14, no complaints or allegations against State Registered Nursing Assistant (SRNA) #1 were received. Other residents under the care of SRNA #1 with a Brief Interview for Mental Status (BIMS) score of eight (8) or above were also interviewed from 03/01/14 to 03/06/14 by the DON, Administrator and/or SS Director with no complaints noted. All the staff working on the same hall as SRNA #1 the evening the alleged abuse occurred were interviewed by the DON, Administrator or SS Director on 03/06/14 and no complaints or concerns were verbalized.
2. SRNA #2 was counseled by the DON immediately via phone on 02/25/14, and in writing on 02/28/14, regarding compliance with the facility's Abuse Policy, and the requirement of immediately reporting all suspected abuse. The DON received education by the Nurse Consultant on 03/05/14 regarding the regulatory

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requirements on reporting and investigating abuse. The DON, Administrator and SS Director received in-service education by the Nurse Consultant on investigation and reporting of abuse on 03/06/14. The re-education included, but was not limited to: identification of events requiring investigation; protecting residents; interviewing residents, staff and all witnesses; and timely reporting of allegations and findings. All facility staff licensed and unlicensed received in-service education on abuse and on the facility's abuse policy, which included: immediately reporting any suspected abuse, neglect, exploitation or misappropriation; and protecting residents. The re-education was provided by the DON, Administrator and SS Director on 03/05/14 through 03/06/14. Any staff on leave, vacation, or unavailable for the in-service would not be able to clock in or work until completing the in-service education. The facility does not utilize agency staffing.

3. A weekly skin assessment performed by the Charge Nurse on 02/22/14, for Resident #1 revealed no suspicious bruising or marks which would indicate physical abuse. Routine skin assessments performed 02/21/14 through 02/27/14, by the Charge Nurses on duty, revealed no suspicious bruising or signs of potential physical abuse of the residents who might have received care by SRNA #1, 02/20/14 through 02/21/14 or any other employee.

4. The investigation was concluded on 03/06/14 with the findings unsubstantiated based on the interviews with Resident #12 and Resident #15 and other cognitively intact residents which revealed no verbal abuse by SRNA #1. Resident #1's roommate/sister had been interviewed and

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F 490	<p>Continued From page 123 denied any abuse by staff.</p> <p>5. All reported allegations were to be reviewed by the facility's investigation team including the Administrator, SS Director and DON immediately during normal business hours to determine which team members would investigate, and report the allegation to the required authorities. During off hours, staff was to notify the DON and/or Administrator immediately via phone; and the DON and/or Administrator would determine who should investigate and report. The Administrator was to report all findings of the facility's investigation team to the Nurse Consultant upon conclusion of the team review, within five (5) working days of the allegation, to determine that all necessary investigation and reporting interventions had been initiated.</p> <p>6. The Continuous Quality Improvement (CQI) indicator for the monitoring for compliance with the components of the abuse regulation, including but not limited to investigating and reporting of abuse, was to be utilized with each allegation of abuse weekly for four (4) weeks, then monthly for four (4) months and then quarterly thereafter under the supervision of the Administrator. Results of each abuse allegation CQI indicator was to be presented by the DON, Administrator or SS Director or designee; and reviewed with the QA team as part of the daily meetings Monday through Friday. Failure to meet the established threshold of one hundred percent (100 %) on the CQI indicator tool would result in intervention; and an immediate internal plan of correction to address the identified areas of concern. The findings of the completed CQI indicators were to be reviewed by the contracted Nurse Consultant with monthly visits, to determine that allegations</p>	F 490		
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F 490	<p>Continued From page 124</p> <p>were investigated and reported as indicated. The effectiveness of the facility's administration would be monitored through the CQI process. Results were to be reported to the QA Committee by the Administrator, DON, SS Director or designee.</p> <p>7. The facility's QA team with the Medical Director convened on 03/06/14 to review the circumstances of the allegations, and all interventions which had been and were to be implemented by the facility.</p> <p>8. The Contracted Nursing Consultant and or Nursing Home Administrator (NHA) consultant will conduct an evaluation of the facility's CQI program monthly for three (3) months, then annually thereafter. Results will be reported to the QA committee.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the facility's documentation revealed the investigation had been re-opened. Review revealed Resident #12 and Resident #15 were re-interviewed on 03/06/14 by the SS Director with additional specific questions and no concerns identified. Review of the documentation revealed Resident #1's roommate/sister had been re-interviewed on 03/06/14 by the SS Director with no concerns noted. Additionally, review revealed seventeen (17) other residents with a BIMS of eight (8) or above had been interviewed between 03/01/14 and 03/06/14 with no concerns identified. Further review revealed all staff members who had worked the West Wing evening shift on 02/20/14, where SRNA #1 allegedly abused residents, were interviewed and had signed Witness Statements, dated 03/06/14.</p>	F 490		
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2. Review of the "Improvement Plan" dated 02/26/14, revealed SRNA #2 had been counseled for not reporting concerns to the supervisor immediately in regards to verbal remarks from another SRNA; and for not following facility policy related to abuse. The Plan was marked as "first counseling" and signed by the DON on 02/28/14. Continued review revealed the DON had attempted to provide a written counseling with SRNA #2 on 02/28/14; however the employee refused to sign it.

Interview with the DON on 03/13/14 at 2:20 PM, revealed she had talked to SRNA #2 about abuse on 02/28/14 and attempted to have her sign a written counseling; however SRNA #2 had refused to sign it.

Review of a sign-in sheet dated 03/06/14, revealed the Administrator, DON and SS Director had attended the Nurse Consultant's inservice on abuse.

Interview with the DON on 03/13/14 at 11:30 AM revealed she had received an inservice from the Nurse Consultant on 03/05/14 and 03/06/14 via phone conference call. She stated the Nurse Consultant educated her on abuse, investigation of abuse, getting statements from residents and staff related to the incident; and regulatory requirements. She stated the Nurse Consultant had also talked about events which would require investigation, types of abuse, how to suspect abuse, protecting residents, and reporting abuse to State Agencies.

Interview with the Administrator on 03/12/14 at 5:27 PM, and the SS Director on 03/12/14 at 4:29

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PM, revealed they had a conference with the Nurse Consultant on 03/06/14; and were educated on identifying abuse, the different types of abuse, what needed to be investigated, interviewing all the staff working with the residents, interviewing residents, having staff turn in a written statement related to the abuse, reporting abuse and time frames for reporting abuse.

Interview with the Nurse Consultant on 03/13/14 at 9:30 AM, revealed she had given training to the Administrator, SS Director and DON on 03/06/14. She further stated the training on abuse had included identification, documentation, conducting interviews, investigation, and timely reporting requirements of abuse.

Review of the facility's inservice education related to abuse revealed it had included the policies on abuse, reporting and investigating abuse, examples of abuse. Review of the facility's documentation revealed staff had taken a post test after the education and signed an acknowledgement form. Continued review of the documentation revealed staff attendance signatures which indicated they had received the abuse inservice on 03/05/14 and 03/06/14. Further review of the inservice education sign-in sheets revealed dietary, housekeeping, nurses, SRNAs, office staff, activities, SS, medical records, laundry and therapy staff had received the education. Additionally, review revealed staff who had not received the education on 03/05/14 and 03/06/14 were inserviced prior to returning to work on 03/07/14 through 03/13/14.

Interview with the Staff Development Nurse on 03/13/14 at 2:05 PM, revealed she had a master

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list of staff with signatures of everyone who had been inserviced; and she had inserviced everyone who had worked so far. The Staff Development Nurse stated the facility had some "PRN" (as needed) staff who had not worked since 03/05/14; and she would inservice those staff before they worked. According to the Staff Development Nurse, the staff abuse inservice covered types of abuse, protecting residents, immediately reporting abuse; and to who and when to report suspected abuse.

Interviews on 03/12/14 with SRNA #8 at 3:20 PM; SRNA #6 at 5:10 PM; SRNA #10 at 5:15 PM; SRNA #9 at 5:56 PM; SRNA #11 at 5:25 PM; LPN #5 at 3:44 PM; LPN #12/Unit Coordinator East Wing at 4:30 PM; LPN #6 at 4:50 PM; LPN #10 at 4:53 PM; LPN #8 at 4:55 PM; LPN #7 at 5:50 PM; RN #2/Unit Manager West Wing at 5:35 PM; Activity Director at 3:45 PM; Activity Assistant at 4:05 PM; Housekeeping Supervisor at 4:15 PM; Laundry Personnel #1 at 4:20 PM; Laundry Personnel #2 at 6:10 PM; Director of Dietary 4:25 PM; Dietary Aide #1 at 4:30 PM; PM Cook at 4:32 PM; Administrative Assistant at 5:10 PM; Bookkeeper at 5:15 PM; and Maintenance Director at 5:40 PM revealed they all had been in-serviced on types of abuse, suspecting abuse, protecting residents and immediately reporting abuse; and to whom to report abuse.

Interviews on 03/13/14 with SRNA #15 at 9:00 AM; SRNA #12 at 9:29 AM; SRNA #13 at 9:36 PM; SRNA #17 at 9:46 PM; SRNA #14 at 10:06 AM; SRNA #1 at 10:34 AM; SRNA #5 at 12:23 PM; SRNA #16 at 12:35 PM; SRNA #2 at 1:23 PM; LPN #11/House Supervisor at 8:50 AM; LPN #13 at 10:55 AM; LPN #12 at 10:26 AM; LPN #4 at 2:24 PM; LPN #14/Quality Assurance Nurse at

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F 490	<p>Continued From page 128</p> <p>2:54 PM; RN #4 at 8:43 PM; RN #5 at 9:56 PM; RN #6 at 11:08 PM; Maintenance Assistance at 9:05 AM; Laundry Personnel #3 at 9:15 AM; Speech Therapist at 10:20 AM; Floor Tech at 10:30 AM; Housekeeping Personnel #1 at 10:45 AM; Business Office Manager at 10:50 AM; and MDS Coordinator at 12:00 PM revealed they all had been in-serviced on types of abuse, suspecting abuse, protecting residents and immediately reporting abuse; and to whom to report abuse.</p> <p>3. Record review revealed a weekly skin assessment was completed on 02/22/14 for Resident #1; which had no documented suspicious bruising or marks that might have indicated physical abuse. Record review revealed routine skin assessments had been completed on 02/21/14 to 02/27/14, for all residents cared for by SRNA #1 on 02/20/14 and 02/21/14, with no documented evidence of suspicious bruising or signs of potential physical abuse noted.</p> <p>4. The facility's re-investigation was reviewed and revealed interviews had been conducted with Resident #12 and Resident #15, and other cognitively intact residents and had revealed no complaints of verbal abuse by SRNA #1. In addition, Resident #1's roommate/sister had been interviewed by the facility and denied any abuse by staff of herself or Resident #1.</p> <p>Interviews on 03/12/14 with Resident #12, Resident #15, Unsampled Resident I, who was Resident #1's roommate/sister, and other cognitively intact residents verified they had been interviewed by facility staff in regards to any staff abuse.</p>	F 490		

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Interview with the Administrator on 03/12/14 at 5:27 PM, and the DON on 03/13/14 at 11:30 AM, revealed they had obtained statements from the residents who had been involved in the allegations; and from other interviewable residents who had been cared for by SRNA #1. The DON and Administrator both stated the facility had not been able to substantiate any of the abuse allegations.

5. Interview with the SS Director on 03/12/14 at 4:29 PM, with the Administrator on 03/12/14 at 5:27 PM, and with the DON on 03/13/14 at 11:30 AM revealed allegations of abuse were to be reviewed by the investigation team and investigations were to be started immediately during normal business hours and the tasks would be delegated. The interviews revealed during off hours staff was to notify the supervisor who would contact the Administrator, SS Director or DON; and they would direct the supervisor on the investigation, and a member of the investigation team would come in. The Administrator stated the findings of the facility's investigation would be reported to the Nurse Consultant during the investigation, and as soon as the investigation was completed for her review. Further interview with the Administrator revealed he, or in his absence the DON, SS Director or designee, would do the reporting to the required authorities within the required time frames.

Interview with the Nurse Consultant on 03/12/14 at 5:45 PM, revealed the facility's investigation team would complete the allegation of abuse investigations, and the Nurse Consultant would be notified of the findings. The Nurse Consultant

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stated he/she would review the facility's investigation to ensure initial reporting had occurred and to ensure the investigation had been completed within the five (5) day time frame for reporting to the State Agency.

6. Review of the facility's CQI Indicator for Abuse Reporting and Investigation tool revealed the components of the abuse regulations were included in the tool; and the tool had a threshold goal of 100%. In addition, the Evaluation of CQI Program tool used to determine if the CQI Indicator tool outcome had been successful or if corrective actions were needed was also reviewed.

Interviews with the Administrator on 03/12/14 at 5:27 PM and the DON on 03/13/14 at 11:30 AM, verified the facility would utilize the CQI Indicator tool when conducting the abuse investigations at a minimum weekly for four (4) weeks, then monthly for four (4) months and then quarterly thereafter as per the AOC. The CQI Indicator tool would be utilized for a longer period of time if necessary which would be determined by the QA Committee. The interviews with the DON and Administrator revealed the CQI tool would take them through the abuse protocol steps; and at the end of the investigation it would help them make sure they had taken the appropriate actions. The Administrator stated the CQI team would supervise the CQI monitor; however he was ultimately responsible. The Administrator stated during abuse investigations the CQI tool results would be presented to the QA team at the daily meetings Monday through Friday; and to the QA Committee monthly. He stated if the established threshold of 100% was not met, they would determine what had gone wrong and set up a

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F 490 Continued From page 131

plan of correction. In addition, the Administrator stated the completed CQI tool would be reviewed by the Nurse Consultant monthly to determine that allegations were investigated and reported appropriately and that thresholds were met.

Interview, on 03/13/14 at 1:54 PM, with the QA Nurse verified the CQI tool for abuse results would be reported to the QA Committee at the monthly meetings. In addition, she stated if the CQI indicator did not meet the threshold they would analyze why it had not met the threshold; and put together an action plan to resolve the area of concern.

7. Review of the 03/06/14 QA Committee Meeting Minutes, no time noted, revealed the QA team had communicated with the Medical Director via phone call and discussed the two (2) allegations of verbal abuse, and one (1) allegation of physical abuse which had occurred on 02/20/14. Continued review revealed the Medical Director was informed the allegations were not reported by the SRNA until 02/25/14 because the SRNA could not find a nurse to report the allegations to. In addition, review of the meeting minutes revealed the QA team and Medical Director discussed what the facility had done to ensure the safety of all residents, and had started the abuse investigation process.

Interviews with the Administrator on 03/12/14 at 5:27 PM and with the DON on 03/13/14 at 11:30 AM revealed the Medical Director was contacted on 03/06/14 regarding the abuse allegations, interviews, what the facility had put in place and the reporting of the abuse.

Interview, on 03/08/14 at 11:30 AM, with the

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F 490 Continued From page 132
Medical Director revealed he was made aware of the Immediate Jeopardy (IJ) situation at the facility on 03/06/14. He stated the facility had discussed with him what had occurred; what the facility had done so far; and what they would be implementing.

8. Interview, on 03/12/14 at 5:45 PM, with the Nurse Consultant verified the Nurse Consultant would conduct an evaluation of the facility's CQI program on the monthly visits for three (3) months, then annually thereafter. According to the Nurse Consultant the results would be reported to the QA Committee.

F 514 483.75(l)(1) RES
SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, and review of the facility's written contract with the

F 490

F 514
Resident records complete/accurate/accessible. (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are--(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.

N 353 902 KAR 20:300-15(10)(a)1. Section 15. Administration(10)Clinical records. (a)The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are: 1. Complete;

Criteria #1 -Podiatry progress notes have been obtained and documented in the charts of residents seen for these services.

Criteria #2 -All residents under the care of the Podiatrist had the potential to be affected by this alleged deficiency.

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F 514 Continued From page 133

Podiatry Service, it was determined the facility failed to maintain a clinical record for each resident that was complete. Record review, on 03/08/14, for two (2) sampled residents (#17 and #22) and twelve (12) unsampled residents (A, B, C, F, G, J, K, L, O, Q, R and S) revealed no Progress Notes were on the charts related to the Podiatrist's evaluations of the residents on 01/07/14.

The findings include:

Interview with the Medical Records Staff Member on 03/08/14 at 6:00 PM, and the facility's Administrator on 03/08/14 at 6:40 PM, revealed the facility did not have a specific policy related to required documentation by outside service providers.

Review of the written Podiatry Agreement, signed by the facility's Administrator on 10/18/11 and by the President of the contracted service on 10/21/11, revealed services provided were to be documented "in a manner and at a level acceptable to the facility and regulatory authorities".

Record review conducted on 03/08/14 for Sampled Residents #17 and #22, and Unsampled Residents A, B, C, F, G, J, K, L, O, Q, R and S, revealed verbal orders for medications were taken from the Podiatrist on 01/07/14 for each of the residents. Continued review revealed no documented evidence of Progress Notes describing the assessment findings during the Podiatrist's visit were present on the residents' charts.

Interview with Medical Records Staff Member #1,

F 514 **Criteria #3** -The SSD had a meeting with the Podiatrist to discuss the need for documented progress notes for all Podiatry services provided. These will be provided to the facility by the Podiatrist within 1 week of provision of the podiatry services.

-Medical records staff have received inservice education from the SDC on the need to file all medical records, including the podiatry progress notes in the resident charts upon receipt, as provided on 4/2/14.

Criteria #4 - The CQI Tool is included for review as Attachment N-14

The CQI tool addressess compliance with the entire regulation, and will be completed monthly X 6 months and then quarterly thereafter under the supervision of the DON. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action. . In addition, the facility utilizes CQI tools specific to aspects of care (i.e., tube feedings, wounds, pain, the RAI process, etc) that review inclusion of the documentation related to that aspect of care in the medical record. These tools are completed by the assigned department head in accordance with the facility CQI calendar, and are reviewed in the QA committee as identified above.

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F 514 Continued From page 134
on 03/08/14 at 6:00 PM, revealed she was not sure of the process for receiving the Progress Notes after a Podiatry visit. She stated the Notes did not come to Medical Records until after they had been reviewed and signed by the nurse and the practitioner. Continued interview revealed she had not received any Podiatry Notes for 01/07/14.

Interview with the Social Worker (SW), on 03/08/14 at 6:07 PM, revealed outside consultants, including the Podiatry Service, left their Progress Notes with her before leaving the building. She stated she did not have any notes from the Podiatry visit on 01/07/14. Continued interview revealed she had not realized the notes were missing until pointed out by the surveyor.

Interview with the Director of Nursing (DON), on 03/08/14 at 6:35 PM, revealed the Podiatrist visited the facility on 01/07/14 and saw residents throughout the facility, including the fourteen (14) residents listed above. She stated she knew the Podiatrist had trouble with her computer that day and was unable to complete her notes as she saw residents. Continued interview revealed the DON did not see the Podiatrist when she left the facility, and was not aware if the Podiatrist made any comment to anyone about providing the notes at a later date.

Interview with the Administrator, on 03/08/14 at 6:40 PM, revealed he was not aware of the missing Progress Notes prior to surveyor intervention. He acknowledged the facility's contract with the Podiatry Service included the provision of documentation related to services provided to the residents.

F 514 Criteria #5 April 9, 2014.

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F 520 | Continued From page 135
F 520 | 483.75(o)(1) QAA
SS=K | COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined the facility failed to maintain a Quality Assessment and Assurance (QA) Program that developed and implemented appropriate plans of action to correct quality deficiencies as evidenced by repeated deficiencies in regards to failure to ensure abuse polices were implemented for three

F 520 | F 520
F 520 | Assurance
The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

N 380 902 KAR 20:300-15(13)(b)2.
Section 15. Administration (13)Quality assessment and assurance.
(b)The quality assessment and assurance committee:
2. Develops and implements appropriate plans of action to correct identified quality deficiencies.

Criteria 1: -SRNA #2 made two allegations of verbal abuse and one allegation of physical abuse on 2/25/14 at 10:30pm to the Director of Nursing (DON). The DON immediately began an investigation. SRNA #1 (the employee whom the allegation was made against) was suspended on 2/26/14 at approximately 3pm by the NHA. The investigation concluded on 2/28/14, and was determined to be unsubstantiated (see bullet point below for basis for allegations to be unsubstantiated). The Lexington Regional OIG office was notified of the allegations and the the facility's findings on 2/28/14.

-The investigation was re-opened on 3/5/14.

-Residents #12 and #15 were interviewed again with additional questions by the DON, NHA and/or the SSD on 3/6/14.

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F 520 Continued From page 136
(3) of twenty-one (21) sampled residents (Resident #1, #12 and #15).

The facility failed to ensure allegations of verbal abuse of Resident #12 and Resident #15; and an allegation of physical abuse of Resident #1 had been reported immediately to the Administrator and to the State Agencies in accordance with State law. In addition, the facility failed to ensure all these alleged violations were fully investigated; and failed to protect residents in order to prevent further potential abuse while the investigation was in progress. (Refer to F-225, F-226, and F-490).

The facility's failure to ensure the Quality Assessment and Assurance (QA) Program developed and implemented appropriate plans of action to correct quality deficiencies was likely to cause risk for serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 03/05/14, and determined to exist on 02/20/14. The facility was notified of the Immediate Jeopardy on 03/05/14.

The facility provided an acceptable Credible Allegation of Compliance (AOC) on 03/12/14 with the facility alleging removal of the Immediate Jeopardy on 03/07/14. The Immediate Jeopardy was verified to be removed on 03/07/14, prior to exiting the facility on 03/13/14, with remaining non-compliance at 42 CFR 483.75, Administration, F-520, with a Scope and Severity of an "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure residents are free from abuse.

In addition, the facility failed to maintain a Quality Assessment and Assurance (QA) Program that

F 520

- Residents #12 and #15 were assessed by the DON and SSD on 2/27/14. No signs of emotional or any type of distress or changes were noted.
- Resident #1 is not interviewable. Her roommate is her sister and was interviewed on 2/27/14 and 3/6/14 by the DON.
- A weekly skin assessment performed by the unit charge nurse on 2/22/14 for Resident #1 revealed no suspicious bruising or marks that would indicate physical abuse.
- Routine weekly skin assessments performed 2/21/14-2/27/28 by the charge nurses on duty reveal no suspicious bruising or signs of potential physical abuse of the residents who may have received care by SRNA #1 on 2/20/14 and/or 2/21/14 (the day the allegations were to have happened and the only day SRNA #2 worked prior to suspension).
- During the resident interviews on 2/27/14 and 3/6/14, the residents interviewed did not make any complaints or allegations against SRNA #1 or any other employee.
- All staff working on the same hall as SRNA #2 when the alleged verbal abuse occurred were interviewed by the DON, NHA and/or Social Services Director (SSD) on 3/6/14; no complaints or concerns were raised.

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F 520	Continued From page 137 developed and implemented appropriate plans of action to correct quality deficiencies as evidenced by repeated deficiencies in regards to the facility's infection control program. The findings include: Review of the Quality Assurance (QA) Program Policy, undated, revealed the QA Program was designed to identify, develop, plan, implement, monitor and ensure correction of deviations from quality. Further review revealed the QA Committee was comprised of the Director of Nursing (DON), Administrator, Medical Director and at least three (3) other members of the facility's staff, and was to meet at least quarterly. 1. Review of the Plan of Correction (POC) dated and signed by the previous Administrator on 06/04/13, with a compliance date of 04/26/13, revealed all staff was inservice on abuse and the facility's abuse policy, including, but not limited to: identification, protection of residents and reporting of abuse on 04/12/13 through 04/16/13. All nurse supervisors and administrative nurses received inservice education on the investigation and reporting of abuse as provided by the DON and Assistant Director of Nursing (ADON) on 04/16/13, including but not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses; and reporting of allegations of findings. Continued review of the POC revealed all allegations were to be reviewed by the facility's investigation team, Administrator, Social Service (SS) Director, DON and ADON, to determine which team members would investigate and report the allegation to the required authorities seven (7) days a week. The	F 520	-SRNA #2 was counseled by the DON via phone on 2/25/14 and in writing on 2/28/14, regarding strict compliance with the facility's Abuse policy and the requirement of immediately reporting all suspected abuse. -The DON received education by the Nurse Consultant on 3/5/14 regarding the regulatory requirements on reporting and investigating allegation of abuse. -The investigation was concluded on 3/6/14 with the findings remaining unsubstantiated. -Basis for allegations to be unsubstantiated: Interviews with the 2 residents involved with the alleged verbal abuse (Residents # 12 & #15) and other cognitively intact residents revealed no verbal abuse by SRNA # 1. The resident involved with the alleged physical abuse (Resident #1) is not interviewable; her roommate/sister was interviewed and denied any abuse by staff to resident. Routine weekly skin assessment of Resident #1 on 2/22/14 by the charge nurse showed no suspicious bruising or signs of physical abuse. Skin assessments of other residents under the care of SRNA revealed no suspicious bruising or sings of physical abuse (refer to Criteria #2). Staff interviews as listed above revealed no concerns with SRNA's care of residents.		

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F 520 Continued From page 138
POC stated the Administrator would complete an allegation check list detailing the required steps of the investigation process from beginning to end to step the investigator through all aspects. If the Administrator was unavailable, the DON or SS Director would complete the checklist. The POC stated the Administrator was to complete an allegation checklist audit for 100% of the allegations made and investigated. The Continuous Quality Improvement (CQI) Indicator for the monitoring of compliance with the components of the abuse regulation would be utilized weekly for four (4) weeks, then monthly thereafter under the supervision of the Administrator. The findings of the completed allegation checklists and CQI indicators would be reviewed by the corporate contracted Nurse Consultant with monthly visits.

On 02/25/14 at approximately 10:30 PM, the House Supervisor, Registered Nurse (RN) #1, was notified by State Registered Nursing Assistant (SRNA) #2, of another SRNA, (SRNA #1) having been verbally abusive to Resident #15 and Resident #12; and physically abusive to Resident #1 on 02/20/14 (five days earlier). However, there was no documented evidence the facility began an investigation until 02/27/14, two (2) days after the Administration became aware of the allegations. Review of the investigation form and interviews revealed the investigation of the alleged abuse consisted of interviewing Resident #12 and Resident #15 on 02/27/14; other interviewable residents were not interviewed until 03/03/14. In addition, the staff who worked at the time of the alleged events, including the alleged perpetrator, SRNA #1 was not interviewed when the facility was notified of the abuse allegations. Also, although Administration became aware of

F 520 -An interdisciplinary infection control team (which includes the DON, QA/Infection Preventionist, West Unit Manager, East Unit Manager, SDC, Wound Care Nurse, PRN staff Dietary Manager and Housekeeping Supervisor) has been established to monitor and review all facility infections and to develop plans of action for any trends, patterns or outbreaks that are identified.

-All infections for the last 30 days have been reviewed to identify any trends or patterns that need to be addressed. Treatments have all been implemented as ordered.
-Residents #17, 19, and 22 did not have any infections identified upon this review on 4/7/14

-Meal service is provided by all staff utilizing infection control standards of practice for hand sanitation, as determined by meal observations performed by administrative nursing staff performed on 3/31/14, 4/2/14 and 4/7/14.

-Resident care/hygiene items are labeled and stored in accordance with infection control standards of practice as determined by weekly. SRNA Room Rounds.

-Peri-care, catheter care, and wound care are provided in accordance with infection control standards of practice as determined by care observations performed by administrative nursing staff on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, and 4/4/14.

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F 520 Continued From page 139
the allegations on 02/25/14, the State Agencies were not notified of the verbal abuse allegations until 02/28/14; and were not notified of the physical abuse allegation until 03/05/14. Additionally, Administration became aware of the abuse allegations on 02/25/14; however, the alleged perpetrator worked on 02/26/14 from 3:00 PM to 3:30 PM, prior to being suspended that day by the Administrator. (Refer to F-225, F-226 and F490).

Interview on 03/07/14 at 12:50 PM with the Director of Nursing revealed the facility reviewed each allegation of abuse daily in the morning Continuous Quality Improvement (CQI) meeting and the Interdisciplinary Plan of Care (IPOC) meeting which included the DON, Minimum Data Set (MDS) Nurses, Social Services (SS), Unit Managers and the Administrator. The DON stated, in the meeting, it was decided who would investigate and report the allegations. She stated the DON, SS, and Administrator all worked as a team on the investigations. Continued interview revealed she completed the allegation checklist for each abuse allegation; however she did not complete the CQI Indicator and did not know if this was still being performed by anyone. The DON called the SS Director during the interview and the SS Director informed the DON she had not been completing the CQI Indicator. The DON stated the Nurse Consultant had been notified of the current allegations on 02/27/14 verbally; however, the Nurse Consultant had not reviewed the facility's investigation.

Interview on 03/07/14 at 12:50 PM with the QA Nurse, revealed the facility discussed any allegations of abuse in QA; however she indicated she had been unable to find any CQI

F 520
Criteria 2: -Routine weekly skin assessments performed 2/21/14-2/27/28 by the charge nurses on duty revealed no suspicious bruising or signs of potential physical abuse of the residents who may have received care by SRNA #1 on 2/20/14 and/or 2/21/14 (the day the allegations were to have happened and the only day SRNA #2 worked prior to suspension).

-Other residents under the care of SRNA #1 with a BIMS score of 8 or higher were interviewed on 3/1/14 and 3/6/14 by the DON, NHA, and/or the SSD with no complaints noted. Based on the findings of these interviews, the need for further resident interviews/assessments was determined to be unnecessary by the investigation team.

-All infections for the last 30 days have been reviewed on 3/31/14 and 4/7/14 to identify any trends or patterns that need to be addressed. Treatments have all been implemented as ordered. All residents with infections, receiving assistance with meals, and receiving peri-care, catheter care, and wound care have the potential to be affected by this alleged deficiency.

Criteria 3: -The DON, NHA and SSD received in-service education by the Nurse Consultant on the investigation and reporting of abuse on 3/6/14. The re-education included, but was not limited to: identification of events requiring investigation; protecting the resident(s); interviewing of residents, staff and all witnesses; and timely reporting of allegations and findings.

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F 520 Continued From page 140
Indicators completed on abuse since 09/27/13. She stated the facility had two (2) new administrators since November 2013.

Interview, on 03/11/14 at 1:14 PM and 03/13/14, with the Administrator revealed he had started his employment at the facility on 12/17/13. He stated he had attended one (1) QA meeting in December 2013; and they had gone over abuse allegations in that meeting. He stated all abuse investigations were still being looked at by the DON, SS, and himself; but the DON took the lead on the investigations and had been completing the allegation checklists since he had been the Administrator. The Administrator stated he had reviewed the current allegation checklist and noted the State Agencies had not been notified timely. He stated the staff members involved should have been interviewed early on; however, after the interviewable residents said nothing happened, he had not felt it was necessary to interview staff. According to the Administrator, the Nurse Consultant had reviewed the facility's investigation related to these allegations and had not notified the facility of any problems with the investigation.

Review of the abuse allegations since December 2013, revealed there had been two (2) misappropriation allegations; and, two (2) abuse allegations and the allegation check list had been completed. However, there was no documented evidence the CQI Indicator had been completed for the four (4) allegations. The Administrator stated, although the abuse allegations were being discussed in the QA meetings, and the allegation checklists completed; the CQI Indicator had not been utilized as per the former POC.

F 520 -All facility staff (licensed and unlicensed) received in-service education on abuse and the facility abuse policy, including, but not limited to: immediately reporting any suspected abuse, neglect, exploitation or misappropriation; and protecting the resident. The re-education was provided by the DON, NHA and SSD on 3/5/14 - 3/6/14. Any staff on leave, vacation, or unavailable for the in-service will not be able to clock in or work until completing the in-service education. The facility does not utilize agency staffing.

-Facility SRNA staff have received inservice education by the SDC on the need to maintain infection control standards of practice for all resident care, including but not limited to: meal assistance, peri-care, and catheter care on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14 and 4/4/14.

-Facility licensed nurses have received inservice education by the SDC on the provision of care in accordance with infection control standards of practice, including but not practice, including but not limited to wound care, on 3/24/14, 3/25/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/31/14, 4/2/14, 4/4/14 and 4/6/14.

Criteria 4: -Contracted nursing consultant and/or NHA consultant will conduct an evaluation of the facility's CQI program monthly X 3, and then annually thereafter. Results will be reported to the QA Committee. (see Evaluation of CQI form)

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F 520	<p>Continued From page 141</p> <p>Interview, on 03/08/14 at 11:30 AM with the Medical Director, revealed he attended the facility's QA meetings monthly and the facility had made him aware of the allegations and Immediate Jeopardy. He stated, after the facility had been cited in April 2013 with Immediate Jeopardy related to abuse, the facility had to ensure all allegations of abuse were thoroughly investigated to include interviewing residents and staff. The Medical Director stated the thorough investigation should include evaluating subjective and objective data, corroborating the information received, and creating an action plan. According to the Medical Director, staff was to immediately report allegations of abuse. He stated the State Agencies were to be notified of abuse allegations within twenty-four (24) hours. The Medical Director indicated when Administration had been notified of the allegations, they should have immediately started the investigation and not allowed SRNA #1 to work.</p> <p>2. Review of the facility's POC, with a compliance date of 05/06/13, revealed nursing staff received in-service education on provision of resident care, including skin assessments, to include hand washing and changing of gloves in accordance with infection control standards of practice. Further review revealed monitoring for handwashing and glove changing during care were to continue monthly for two (2) months and then every six (6) months thereafter.</p> <p>Observation during the current survey of Resident #6's skin assessment, revealed the nurse assessed the resident's buttock area touching the buttocks; and then without washing or sanitizing her hands and changing her gloves, assessed the resident's vaginal/perineal area.</p>	F 520	<p>-The Administrator will report all findings of the facility investigation team to the Nurse Consultant upon conclusion of the team review (within 5 working days of the allegation) to determine that all necessary investigation and reporting interventions have been initiated.</p> <p>-Results of each Abuse Allegation CQI indicator shall be presented by the NHA/DON/SSD or designee and reviewed with the QA team as part of the daily meetings (M-F). The CQI Tools are included for review as Attachment A-8 and IC-2. The CQI Tools address compliance with the entire regulation and will be completed by the Administrator (A-8 weekly X 4 weeks then as described) and DON (IC-2) monthly X 6 months and then quarterly thereafter. Results of the audits will be reported to the QA Committee by Department Heads monthly for six (6) months and quarterly thereafter. If an accepted threshold of threshold of compliance, as referenced on the CQI Tool, is not achieved, the appropriate Department Head shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. If appropriate compliance is not achieved at that time, the responsible Department Head will face personnel action.</p> <p>Criteria 5: April 9, 2014.</p>	
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F 520	<p>Continued From page 142</p> <p>Interview, on 03/06/14 at 5:54 PM and on 03/11/14 2 PM, with the QA/Infection Control (IC) Nurse revealed the nurse should have assessed the resident's perineal/vaginal area first; and then the buttock area to prevent cross contamination. She stated there were two (2) CQI audits performed for general infection control which had been done on 10/11/13; however, these audits had not included observation of skin assessments. She indicated however, the observation of skin assessments had still been done every six (6) months; and three (3) observations of skin assessments were done in November 2013.</p> <p>Interview with the DON, on 03/08/14 at 2:22 PM, revealed she indicated the issues identified with handwashing and skin assessments were infection control issues because of the possibility of transferring potentially harmful organisms. She further stated the facility had not had ongoing audits of handwashing and the current role of the ICN had been to track and trend infections only.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC), on 03/12/14 which alleged removal of the Immediate Jeopardy on 03/07/14. Review of the AOC revealed the facility implemented the following:</p> <p>1. The investigation was reopened on 03/05/14. Residents #12 and #15 were re-interviewed with additional questions by the DON, Administrator and/or Social Services (SS) Director on 03/06/14. Resident #1's roommate, which was the resident's sister was interviewed on 03/06/14, by the DON because Resident #1 was not interviewable. During the resident interviews on</p>	F 520		

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F 520	<p>Continued From page 143</p> <p>03/06/14, no complaints or allegations against State Registered Nursing Assistant (SRNA) #1 were received. Other residents under the care of SRNA #1 with a Brief Interview for Mental Status (BIMS) score of eight (8) or above were also interviewed from 03/01/14 to 03/06/14 by the DON, Administrator and/or SS Director with no complaints noted. All the staff working on the same hall as SRNA #1 the evening the alleged abuse occurred were interviewed by the DON, Administrator or SS Director on 03/06/14 and no complaints or concerns were verbalized.</p> <p>2. SRNA #2 was counseled by the DON immediately via phone on 02/25/14, and in writing on 02/28/14, regarding compliance with the facility's Abuse Policy; and the requirement of immediately reporting all suspected abuse. The DON received education by the Nurse Consultant on 03/05/14 regarding the regulatory requirements on reporting and investigating abuse. The DON, Administrator and SS Director received in-service education by the Nurse Consultant on investigation and reporting of abuse on 03/06/14. The re-education included, but was not limited to: identification of events requiring investigation; protecting residents; interviewing residents, staff and all witnesses; and timely reporting of allegations and findings. All facility staff licensed and unlicensed received in-service education on abuse and on the facility's abuse policy, which included: immediately reporting any suspected abuse, neglect, exploitation or misappropriation; and protecting residents. The re-education was provided by the DON, Administrator and SS Director on 03/05/14 through 03/06/14. Any staff on leave, vacation, or unavailable for the in-service would not be able to clock in or work until completing the in-service</p>	F 520	

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F 520 Continued From page 144 education. The facility does not utilize agency staffing.

3. A weekly skin assessment performed by the Charge Nurse on 02/22/14, for Resident #1 revealed no suspicious bruising or marks which would indicate physical abuse. Routine skin assessments performed 02/21/14 through 02/27/14, by the Charge Nurses on duty, revealed no suspicious bruising or signs of potential physical abuse of the residents who might have received care by SRNA #1, 02/20/14 through 02/21/14 or any other employee.

4. The investigation was concluded on 03/06/14 with the findings unsubstantiated based on the interviews with Resident #12 and Resident #15 and other cognitively intact residents which revealed no verbal abuse by SRNA #1. Resident #1's roommate/sister had been interviewed and denied any abuse by staff.

5. All reported allegations were to be reviewed by the facility's investigation team including the Administrator, SS Director and DON immediately during normal business hours to determine which team members would investigate, and report the allegation to the required authorities. During off hours, staff was to notify the DON and/or Administrator immediately via phone; and the DON and/or Administrator would determine who should investigate and report. The Administrator was to report all findings of the facility's investigation team to the Nurse Consultant upon conclusion of the team review, within five (5) working days of the allegation, to determine that all necessary investigation and reporting interventions had been initiated.

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F 520 Continued From page 145

6. The Continuous Quality Improvement (CQI) indicator for the monitoring for compliance with the components of the abuse regulation, including but not limited to investigating and reporting of abuse, was to be utilized with each allegation of abuse weekly for four (4) weeks, then monthly for four (4) months and then quarterly thereafter under the supervision of the Administrator. Results of each abuse allegation CQI indicator was to be presented by the DON, Administrator or SS Director or designee; and reviewed with the QA team as part of the daily meetings Monday through Friday. Failure to meet the established threshold of one hundred percent (100 %) on the CQI indicator tool would result in intervention; and an immediate internal plan of correction to address the identified areas of concern. The findings of the completed CQI indicators were to be reviewed by the contracted Nurse Consultant with monthly visits, to determine that allegations were investigated and reported as indicated. The effectiveness of the facility's administration would be monitored through the CQI process. Results were to be reported to the QA Committee by the Administrator, DON, SS Director or designee.

7. The facility's QA team with the Medical Director convened on 03/06/14 to review the circumstances of the allegations, and all interventions which had been and were to be implemented by the facility.

8. The Contracted Nursing Consultant and or Nursing Home Administrator (NHA) consultant will conduct an evaluation of the facility's CQI program monthly for three (3) months, then annually thereafter. Results will be reported to the QA committee.

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F 520	<p>Continued From page 146</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 the facility's documentation revealed the investigation had been re-opened. Review revealed Resident #12 and Resident #15 were re-interviewed on 03/06/14 by the SS Director with additional specific questions and no concerns identified. Review of the documentation revealed Resident #1's roommate/sister had been re-interviewed on 03/06/14 by the SS Director with no concerns noted. Additionally, review revealed seventeen (17) other residents with a BIMS of eight (8) or above had been interviewed between 03/01/14 and 03/06/14 with no concerns identified. Further review revealed all staff members who had worked the West Wing evening shift on 02/20/14, where SRNA #1 allegedly abused residents, were interviewed and had signed Witness Statements, dated 03/06/14. 2. Review of the "Improvement Plan" dated 02/26/14, revealed SRNA #2 had been counseled for not reporting concerns to the supervisor immediately in regards to verbal remarks from another SRNA; and for not following facility policy related to abuse. The Plan was marked as "first counseling" and signed by the DON on 02/28/14. Continued review revealed the DON had attempted to provide a written counseling with SRNA #2 on 02/28/14; however the employee refused to sign it. <p>Interview with the DON on 03/13/14 at 2:20 PM, revealed she had talked to SRNA #2 about abuse on 02/28/14 and attempted to have her sign a written counseling; however SRNA #2 had refused to sign it.</p>	F 520		

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F 520 Continued From page 147
Review of a sign-in sheet dated 03/06/14, revealed the Administrator, DON and SS Director had attended the Nurse Consultant's inservice on abuse.

Interview with the DON on 03/13/14 at 11:30 AM revealed she had received an inservice from the Nurse Consultant on 03/05/14 and 03/06/14 via phone conference call. She stated the Nurse Consultant educated her on abuse, investigation of abuse, getting statements from residents and staff related to the incident; and regulatory requirements. She stated the Nurse Consultant had also talked about events which would require investigation, types of abuse, how to suspect abuse, protecting residents, and reporting abuse to State Agencies.

Interview with the Administrator on 03/12/14 at 5:27 PM, and the SS Director on 03/12/14 at 4:29 PM, revealed they had a conference with the Nurse Consultant on 03/06/14; and were educated on identifying abuse, the different types of abuse, what needed to be investigated, interviewing all the staff working with the residents, interviewing residents, having staff turn in a written statement related to the abuse, reporting abuse and time frames for reporting abuse.

Interview with the Nurse Consultant on 03/13/14 at 9:30 AM, revealed she had given training to the Administrator, SS Director and DON on 03/06/14. She further stated the training on abuse had included identification, documentation, conducting interviews, investigation, and timely reporting requirements of abuse.

Review of the facility's inservice education related

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to abuse revealed it had included the policies on abuse, reporting and investigating abuse, examples of abuse. Review of the facility's documentation revealed staff had taken a post test after the education and signed an acknowledgement form. Continued review of the documentation revealed staff attendance signatures which indicated they had received the abuse inservice on 03/05/14 and 03/06/14. Further review of the inservice education sign-in sheets revealed dietary, housekeeping, nurses, SRNAs, office staff, activities, SS, medical records, laundry and therapy staff had received the education. Additionally, review revealed staff who had not received the education on 03/05/14 and 03/06/14 were inserviced prior to returning to work on 03/07/14 through 03/13/14.

Interview with the Staff Development Nurse on 03/13/14 at 2:05 PM, revealed she had a master list of staff with signatures of everyone who had been inserviced; and she had inserviced everyone who had worked so far. The Staff Development Nurse stated the facility had some "PRN" (as needed) staff who had not worked since 03/05/14; and she would inservice those staff before they worked. According to the Staff Development Nurse, the staff abuse inservice covered types of abuse, protecting residents, immediately reporting abuse; and to who and when to report suspected abuse.

Interviews on 03/12/14 with SRNA #8 at 3:20 PM; SRNA #6 at 5:10 PM; SRNA #10 at 5:15 PM; SRNA # 9 at 5:56 PM; SRNA #11 at 5:25 PM; LPN #5 at 3:44 PM; LPN #12/Unit Coordinator East Wing at 4:30 PM; LPN #6 at 4:50 PM; LPN # 10 at 4:53 PM; LPN #8 at 4:55 PM; LPN #7 at 5:50 PM; RN #2/Unit Manager West Wing at 5:35

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F 520	<p>Continued From page 149</p> <p>PM; Activity Director at 3:45 PM; Activity Assistant at 4:05 PM; Housekeeping Supervisor at 4:15 PM; Laundry Personnel #1 at 4:20 PM; Laundry Personnel #2 at 6:10 PM; Director of Dietary 4:25 PM; Dietary Aide #1 at 4:30 PM; PM Cook at 4:32 PM; Administrative Assistant at 5:10 PM; Bookkeeper at 5:15 PM; and Maintenance Director at 5:40 PM revealed they all had been in-serviced on types of abuse, suspecting abuse, protecting residents and immediately reporting abuse; and to whom to report abuse.</p> <p>Interviews on 03/13/14 with SRNA #15 at 9:00 AM; SRNA #12 at 9:29 AM; SRNA #13 at 9:36 PM; SRNA #17 at 9:46 PM; SRNA #14 at 10:06 AM; SRNA #1 at 10:34 AM; SRNA #5 at 12:23 PM; SRNA #16 at 12:35 PM; SRNA #2 at 1:23 PM; LPN # 11/House Supervisor at 8:50 AM; LPN #13 at 10:55 AM; LPN #12 at 10:26 AM; LPN #4 at 2:24 PM; LPN #14/Quality Assurance Nurse at 2:54 PM; RN #4 at 8:43 PM; RN #5 at 9:56 PM; RN #6 at 11:08 PM; Maintenance Assistance at 9:05 AM; Laundry Personnel #3 at 9:15 AM; Speech Therapist at 10:20 AM; Floor Tech at 10:30 AM; Housekeeping Personnel #1 at 10:45 AM; Business Office Manager at 10:50 AM; and MDS Coordinator at 12:00 PM revealed they all had been in-serviced on types of abuse, suspecting abuse, protecting residents and immediately reporting abuse; and to whom to report abuse.</p> <p>3. Record review revealed a weekly skin assessment was completed on 02/22/14 for Resident #1; which had no documented suspicious bruising or marks that might have indicated physical abuse. Record review revealed routine skin assessments had been completed on 02/21/14 to 02/27/14, for all</p>	F 520		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 520 Continued From page 150 residents cared for by SRNA #1 on 02/20/14 and 02/21/14, with no documented evidence of suspicious bruising or signs of potential physical abuse noted.

4. The facility's re-investigation was reviewed and revealed interviews had been conducted with Resident #12 and Resident #15, and other cognitively intact residents and had revealed no complaints of verbal abuse by SRNA #1. In addition, Resident #1's roommate/sister had been interviewed by the facility and denied any abuse by staff of herself or Resident #1.

Interviews on 03/12/14 with Resident #12, Resident #15, Unsamped Resident I, who was Resident #1's roommate/sister, and other cognitively intact residents verified they had been interviewed by facility staff in regards to any staff abuse.

Interview with the Administrator on 03/12/14 at 5:27 PM, and the DON on 03/13/14 at 11:30 AM, revealed they had obtained statements from the residents who had been involved in the allegations; and from other interviewable residents who had been cared for by SRNA #1. The DON and Administrator both stated the facility had not been able to substantiate any of the abuse allegations.

5. Interview with the SS Director on 03/12/14 at 4:29 PM, with the Administrator on 03/12/14 at 5:27 PM, and with the DON on 03/13/14 at 11:30 AM revealed allegations of abuse were to be reviewed by the investigation team and investigations were to be started immediately during normal business hours and the tasks would be delegated. The interviews revealed

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F 520	<p>Continued From page 151</p> <p>during off hours staff was to notify the supervisor who would contact the Administrator, SS Director or DON; and they would direct the supervisor on the investigation, and a member of the investigation team would come in. The Administrator stated the findings of the facility's investigation would be reported to the Nurse Consultant during the investigation, and as soon as the investigation was completed for her review. Further interview with the Administrator revealed he, or in his absence the DON, SS Director or designee, would do the reporting to the required authorities within the required time frames.</p> <p>Interview with the Nurse Consultant on 03/12/14 at 5:45 PM, revealed the facility's investigation team would complete the allegation of abuse investigations, and the Nurse Consultant would be notified of the findings. The Nurse Consultant stated he/she would review the facility's investigation to ensure initial reporting had occurred and to ensure the investigation had been completed within the five (5) day time frame for reporting to the State Agency.</p> <p>6. Review of the facility's CQI Indicator for Abuse Reporting and Investigation tool revealed the components of the abuse regulations were included in the tool; and the tool had a threshold goal of 100%. In addition, the Evaluation of CQI Program tool used to determine if the CQI Indicator tool outcome had been successful or if corrective actions were needed was also reviewed.</p> <p>Interviews with the Administrator on 03/12/14 at 5:27 PM and the DON on 03/13/14 at 11:30 AM, verified the facility would utilize the CQI Indicator</p>	F 520		

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F 520 Continued From page 152

tool when conducting the abuse investigations at a minimum weekly for four (4) weeks, then monthly for four (4) months and then quarterly thereafter as per the AOC. The CQI Indicator tool would be utilized for a longer period of time if necessary which would be determined by the QA Committee. The interviews with the DON and Administrator revealed the CQI tool would take them through the abuse protocol steps; and at the end of the investigation it would help them make sure they had taken the appropriate actions. The Administrator stated the CQI team would supervise the CQI monitor; however he was ultimately responsible. The Administrator stated during abuse investigations the CQI tool results would be presented to the QA team at the daily meetings Monday through Friday; and to the QA Committee monthly. He stated if the established threshold of 100% was not met, they would determine what had gone wrong and set up a plan of correction. In addition, the Administrator stated the completed CQI tool would be reviewed by the Nurse Consultant monthly to determine that allegations were investigated and reported appropriately and that thresholds were met.

Interview, on 03/13/14 at 1:54 PM, with the QA Nurse verified the CQI tool for abuse results would be reported to the QA Committee at the monthly meetings. In addition, she stated if the CQI indicator did not meet the threshold they would analyze why it had not met the threshold; and put together an action plan to resolve the area of concern.

7. Review of the 03/06/14 QA Committee Meeting Minutes, no time noted, revealed the QA team had communicated with the Medical Director via phone call and discussed the two (2) allegations

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F 520	<p>Continued From page 153</p> <p>of verbal abuse, and one (1) allegation of physical abuse which had occurred on 02/20/14. Continued review revealed the Medical Director was informed the allegations were not reported by the SRNA until 02/25/14 because the SRNA could not find a nurse to report the allegations to. In addition, review of the meeting minutes revealed the QA team and Medical Director discussed what the facility had done to ensure the safety of all residents, and had started the abuse investigation process.</p> <p>Interviews with the Administrator on 03/12/14 at 5:27 PM and with the DON on 03/13/14 at 11:30 AM revealed the Medical Director was contacted on 03/06/14 regarding the abuse allegations, interviews, what the facility had put in place and the reporting of the abuse.</p> <p>Interview, on 03/08/14 at 11:30 AM, with the Medical Director revealed he was made aware of the Immediate Jeopardy (IJ) situation at the facility on 03/06/14. He stated the facility had discussed with him what had occurred; what the facility had done so far; and what they would be implementing.</p> <p>8. Interview, on 03/12/14 at 5:45 PM, with the Nurse Consultant verified the Nurse Consultant would conduct an evaluation of the facility's CQI program on the monthly visits for three (3) months, then annually thereafter. According to the Nurse Consultant the results would be reported to the QA Committee.</p>	F 520		

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{K 000}	<p>INITIAL COMMENTS</p> <p>A review of the facilities Plan of Correction was completed on 04-14-14 and was found to be acceptable. The LSC deficiencies were deemed to be corrected on 04/09/14 as alleged in the POC.</p> <p>The facility meets the minimum requirements for participation in the Medicare and Medicaid program.</p>	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type V (111) Unprotected</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed in 1974</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM) original in 1974</p> <p>EMERGENCY POWER: Type II Diesel Generator. Original in 1974</p> <p>A Standard Life Safety Code Survey was initiated and concluded on 03/05/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred eighteen (118) beds and the census was one hundred and three (103) the day of the survey.</p>	K 000	<p>Plan of Correction</p> <p>Cambridge Place</p> <p>Abbreviated Standard/Partial</p> <p>Extended Survey 4/24/2013</p> <p>The preparation and execution of this credible allegation of compliance does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. The facility further disputes that the circumstances constituted immediate jeopardy to any resident. This credible allegation of compliance is prepared and executed solely because it is required by federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dennis Dr. Holt</i>	TITLE Administrator	(X6) DATE 4/8/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000 Continued From page 1
Deficiencies were cited with the highest Scope and Severity of an "E".

K 000

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

K 029

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

K 029 NFPA 101 Life Safety Code Standard
One hour fire rated construction or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas.

Criteria 1: The janitor closets across from room #51 and by the beauty shop have had repairs to the dry wall and penetrations in the walls by the Maintenance Director.

Criteria 2: The Maintenance Director completed an inspection of all janitor closets in the facility to identify any requiring repair of the dry wall. No other areas were identified.

Criteria 3: The maintenance staffs have received in-service education by the Administrator on 4/4/2014 on the need to identify and repair any penetrations in the dry wall which would allow the passage of smoke.

Criteria 4: The CQI indicator for the monitoring of Life Safety issues including the identifying and repair of any penetrations in the dry wall will be utilized monthly X 2 months and then quarterly under the supervision of the Maintenance Director.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain hazardous areas, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect two (2) of seven (7) smoke compartments, sixty-seven (67) residents, staff and visitors.

Criteria 5:

April 7, 2014

The findings include:

Observation, on 03/05/14 at 9:36 AM, revealed the Janitor Closet across from room #51 had a 4 inch by 12 inch section of drywall missing at the floor level as well as several half inch penetrations not sealed to prevent the passage of smoke. The same was observed at 10:25 AM in the janitor's closet beside the beauty shop.

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K 029	Continued From page 2 Penetrations must be sealed with a material equal or greater than the original construction to resist the passage of smoke during a fire. Interview, on 03/05/14 at 10:32 AM, with the Maintenance Director, revealed he was unaware of the penetrations, but would get the repairs made as soon as possible. Interview, on 03/05/14 at 11:35 AM, with the Administrator revealed he was unaware of the penetrations and would get them repaired immediately. Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction	K 029			

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K 029	Continued From page 3 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility had an adequate number of electrical receptacles to meet the needs of residents without the use of extension cords or multiple outlet adapters according to National Fire Protection Association (NFPA). The deficiency had the potential to affect two (2) smoke compartments, two (2) residents, staff and visitors. The findings include: Observation, on 03/05/14 at 9:15 AM, with the Maintenance Director revealed a multi-outlet strip being used as permanent wiring in the Lobby, two (2) lamps and Christmas lights were observed plugged into the power strip. Also the cord was permanently fastened to the wall. Observation in room #64 at 10:25 AM, revealed a power strip	K 147	K 147 NFPA 101 Life Safety Code Standards Electrical wiring and equipment is in accordance with NFPA 70. National Electrical Code 9.1.2. Criteria 1: The power strips were removed from the lobby and room #64. Criteria 2: The Maintenance Director completed an inspection of all resident care and common areas with no other power strips identified in use. Criteria 3: The maintenance staff has received in-service education on the need to plug electrical equipment and appliances directly into the receptacles, with no use of power strips in resident care or common areas as provided by the Administrator on 4/4/2014 Criteria 4: The CQI indicator for the monitoring of Life Safety issues including no use of power strips in resident care or common areas will be utilized monthly X 2 months and then quarterly under the supervision of the Maintenance Director. Criteria #5 April 9, 2014

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K 147	<p>Continued From page 4</p> <p>was being used as permanent wiring to power a television, radio, and alarm clock. In addition, extension cords and multi-outlet strips cannot be used as a substitute for permanent wiring.</p> <p>Interview, on 03/05/14, at 9:15 AM, with the Maintenance Director revealed he was unaware that he could not use the power strip in this application.</p> <p>Interview on 03/05/14 at 11:30 AM with the Administrator revealed he would have the power strip removed immediately and would educate the staff on power strips.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces <p>Exception: Flexible cord and cable shall be</p>	K 147		

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K 147 Continued From page 5
permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.
5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors
6. Where installed in raceways, except as otherwise permitted in this Code.

K 147