

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/11/2014
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
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08/30/14 to ensure he was aware of the above concerns. He stated he was aware and had been notified by facility staff. No other concerns were expressed.

8. On 08/30/14 at 3:05 PM, the Attending Physician for Resident #1 and Resident #2 was contacted by the Vice President of Clinical Services. The Physician stated he was well aware of (Resident #2's) change in behavior. He stated he informed the surveyor he had been notified and updated concerning both residents (#1 and #2).

9. Based on the weekly skin assessments, all residents with identified skin areas were reviewed in the weekly Quality of Care meetings by the Interdisciplinary Team on 07/25/14 and 08/07/14.

A Quality Assurance process was implemented by the Administrator on 08/29/14 to monitor on a continuing basis this Allegation of Compliance through a daily monitoring meeting during which the Administrator, DON, Assistant DON, charge nurses and therapy team review Physician orders, nursing supervisor reports, 24-hour nursing communication sheets, care plan revisions, conduct daily physical rounds in the facility, review incident reporting and ensure appropriate Physician and legal representative notifications. The daily monitoring will continue for the next three (3) months and weekly thereafter.

The facility will also utilize the Interact II Stop and Watch Program to gather input from all staff regarding any changes noted or observed with any resident's behavior or otherwise.

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to the resident's care plan.

4. A quality assurance process is in place to audit 10% of records on a monthly basis to ensure compliance. This audit will be completed by the Director of Nursing or the Assistant Director of Nursing. The DON will audit 10% of records on a monthly basis to ensure compliance and identify any deficient practice. This audit is in addition to the audit conducted daily in morning meeting which provides frequent monitoring to ensure the facility is maintaining compliance. Once a Stop and Watch tool

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In the absence of the Administrator, the DON will assume the responsibility. On weekends, the Charge Nurse will complete this process.

The DON will conduct a quality assurance audit for accuracy of clinical records on 10% of records on a monthly basis to ensure compliance.

10. For continued monitoring of the Allegation of Compliance, a member of the governing body, either the Executive Vice President or the Vice President of Clinical Services, will be in attendance at monthly quality assurance meetings for the next three (3) months.

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

1. Copies of skin assessments, performed by licensed staff, for Resident #1 on 07/28/14 and 08/05/14 were reviewed. No concerns were revealed during this review. A review of the complete assessment by the Physician on 07/31/14 revealed no concerns.
2. A review of every 15 minute checks of Resident #2 by nursing staff, for the period of 07/26/14 through 07/30/14, revealed no concerns. Observation of Resident #2 on 09/04/14 at 10:05 AM, revealed the resident to be sitting in the dining room with a staff member playing cards. Interview with SRNA #6 on 09/04/14 at 10:09 AM, revealed she was assigned to do 1:1 with Resident #2. Interview with the Administrator on 09/11/14 at 1:55 PM, confirmed Resident #2 was started on 1:1 monitoring on 08/29/14 and the monitoring was ongoing.

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has been initiated by a staff member, one copy is immediately given to the licensed nurse and the other copy is given to the DON for follow up and discussed in the interdisciplinary daily morning meeting. Upon completion of the assessment by the licensed nurse, any new problems, orders or interventions would be applied to the care plan. In addition, all Stop and Watch forms are discussed in the daily morning meetings to make the interdisciplinary team of possible changes in condition of residents and the need for care plan revisions. The MDS Coordinator

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3. The facility provided the in-service sign in sheets for training of the Administrator and the DON on 08/29/14, by the Vice President of Clinical Services, related to the following: accuracy of clinical records related to documentation and notification of the Physician and the POA; the definitions of abuse; identification, reporting and investigation of abuse; implementation of the facility's Protection Policy; and care plan revisions. Interview with the Administrator on 09/11/14 at 1:47 PM, and the DON on 09/11/14 at 1:35 PM, revealed both had attended the in-service training and were able to verbalize their understanding of the education.

4. The facility provided a copy of the in-service sign-in sheets for 08/29/14 and 08/30/14. Review of the records revealed training was provided for all staff regarding the following: accuracy of the clinical record; documentation and notification of the Physician and the POA; definitions of abuse; identification, reporting and investigating abuse; and revision of care plans.

Interview with SRNA #10 on 09/11/14 at 2:25 PM, revealed she had attended the in-service related to abuse. Interview with SRNA/Restorative #9, on 09/11/14 at 1:23 PM, revealed she had attended the in-service related to abuse and how to respond. Interview with the Housekeeping Supervisor on 09/11/14 at 1:30 PM, revealed she had attended the in-services related to abuse, documentation, and notification. Interview with Maintenance staff on 09/11/14 at 1:12 PM, revealed he had attended the abuse in-services. Interview with the Activity Assistant, on 09/11/14 at 1:26 PM, revealed she had received training on abuse and attended the in-service on 08/30/14. Interview with RN #2, on 09/11/14 at 1:25 PM,

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attends the daily morning meeting and ensures compliance with the revision of resident care plans based on the information reviewed; physician's orders, incident reports, and nursing communication reports. The charge nurses complete the daily audit process on the weekends. The results of the audit from the weekend charge nurses are reviewed by the Administrator, DON or ADON on the following work day. The Administrator has the documentation of the completion of the daily audits and the weekend audit

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revealed she attended the in-service on 08/29/14 related to abuse, documentation, notification, reporting, identifying, investigating, and revision of care plans.

5. The facility provided a copy of audits completed, beginning 08/30/14 and ending 09/02/14, for all resident records regarding accurate notification of the Physician and the legal representative, and a review of resident assessments and care plans to ensure completeness and accuracy. Review of the audit completed on 08/30/14, related to residents who triggered on the MDS assessment for behaviors that affect others, revealed the care plans reflected current interventions. Interview with RN #2/MDS Nurse, on 09/11/14 at 1:05 PM, revealed all resident records were reviewed for documentation, Physician and POA notification, current behavior interventions, and complete and accurate assessments and care plans.

6. The facility provided interview audits completed on 08/30/14 for female residents, and on 09/02/14 for male residents, regarding whether they had been touched inappropriately by a male resident or anyone since residing at the facility. No concerns were voiced by any residents.

7. Interview with the POA for Resident #2, on 09/04/14 at 9:20 AM, revealed she had spoken with the vice President of Clinical Services and the Administrator. She confirmed she was not sure when she was first notified, but she was now aware of all allegations of inappropriate behavior on the part of Resident #2, and was aware of actions taken by the facility.

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documentation from charge nurses is forwarded to the Administrator for review. Any issues noted through this process regarding notification receives immediate followed up and the appropriate interventions/actions occur. The results of the daily auditing and monitoring will be made part of the monthly QA meeting by the Administrator and will continue for the next 6 months.

5. 09-15-14

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It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to provide care by persons in

Interview with the POA for Resident #1, on

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09/10/14 at 4:30 PM, revealed he had spoken with the Vice President of Clinical Services and told her we was aware of the inappropriate behavior toward his mother, as he had been told by facility staff.

8. Interview with the Attending Physician for Resident #1 and Resident #2, on 09/10/14 at 5:35 PM, revealed he had spoken with the Vice President of Clinical Services and was aware of Resident #2's change in behavior.

9. Review of the Quality of Care meeting minutes revealed residents with identified skin areas were reviewed on 07/25/14 and 08/07/14. Interview with the Administrator, on 09/11/14 at 5:10 PM, revealed the team met daily to monitor care plan revisions, incident reporting, and appropriate notification of the Physician and POA. The medical record audit is scheduled to be initiated 09/17/14 and completed by the end of each month. Review of the audit tool utilized to monitor 10% of resident records for accuracy on a monthly basis revealed no concerns.

10. Interview with the Vice President of Clinical Services on 09/11/14 at 5:00 PM, revealed she or the Executive Vice President of Clinical Services would attend the monthly QA meeting for three (3) months. Monthly QA meetings are scheduled 09/17/14, 10/15/14, and 11/19/14.

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

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

F 280 accordance with each resident's written care plan.

1. Resident #2's care plan was revised by the MDS nurse on the following dates: 07-26-14, 07-30-14, 08-04-14, and 08-28-14 with a problem of "inappropriate behaviors" and interventions of every fifteen minute monitoring, transfer to hospital and a room/wing change. On 08-29-14 at 9:00 P. M., one-on-one monitoring for Resident #2's alleged targeting behavior was added to the care plan. Resident #1's care plan did not change as a result of the contact by Resident #2.

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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 residents' Comprehensive Care Plans were implemented to ensure supervision and residents were protected from abuse for one (1) of eight (8) sampled residents (Resident #2).

Interviews with nurses and State Registered Nursing Assistants (SRNAs) revealed Resident #2 was observed touching Resident #1 inappropriately on several different occasions. On 07/26/14, a visitor pointed at Resident #1 and Resident #2 and told a SRNA "you need to do something about this", as Resident #2 was observed with his/her hand inside the waist band of Resident #1's pants. On 7/28/14, Resident #2 had his/her hand under Resident's #1's shirt. On 07/30/14 sought out Resident #1, displayed inappropriate behaviors (touching inappropriately), was difficult to redirect, and was sent out to the hospital for a psychiatric (psych) evaluation. On 08/04/14, Resident #2 was readmitted and the resident's care plan was revised to perform every fifteen (15) minute checks of the resident. However, review of the "Monitoring" forms revealed no documented evidence the every fifteen (15) minutes checks were completed 08/04/14 through 08/08/14. On 08/04/14 Resident #2 was observed on two (2) separate occasions that day to have more than half of his/her hand in Resident #1's pants, once near Resident #1's pubic area down the front of the resident's pants and the other time in the groin area up the resident's pant's leg. In

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2. All resident care plans were reviewed starting on 08-30-14 and ending on 09-02-14 by the Director of Nursing, MDS staff, Admissions Nurse and Administrative nurses for completeness and accuracy. All licensed staff are aware that the care plan is to be revised with any change in the resident's condition utilizing the communication form. The DON, MDS staff, ADON/Admissions nurse, and administrative nurses audited all resident care plans to ensure accuracy to reflect current interventions and physician's orders through observation,

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 addition, staff interviews revealed Resident #2 tried unsuccessfully on other occasions to seek out Resident #1; however, staff intervened before he/she was able to touch Resident #1. On 08/09/14 at 10:40 AM Resident #2 was found in Resident #1's room again, redirected out of the room; however, continued to return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation. (Refer to F-223)

The facility's failure to have an effective system in place to ensure the Comprehensive Care Plan was implemented for supervision and protection of other residents to prevent further abuse was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 08/29/14 and was determined to exist on 07/26/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The Immediate Jeopardy was verified to be removed on 09/03/14 prior to exiting the facility on 09/11/14, with remaining non-compliance at 42 CFR 483.20, Resident Assessment, F-280 Care Plan Revision, with a Scope and Severity of "D" while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Care Plans-Comprehensive" dated 08/01/13, revealed the an individualized comprehensive care plan which included measurable objectives and

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 communication of front line staff and comparison of documented needs in relationship to the care plan.

3. Daily the interdisciplinary team reviews the physicians' orders, nursing supervisor reports, daily, the 24 hour nursing communication sheets and incident reports. The Interact II Stop and Watch Program is also used to ensure care plans are up to date and accurate. All staff were educated on the importance of care plan interventions and the proper implementation of such interventions on 8/29/14 and completed

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F 282	<p>Continued From page 86</p> <p>timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. The Policy revealed care plans were developed based on a thorough assessment which included the the Minimum Data Set (MDS) Assessment.</p> <p>Interview with staff revealed Resident #2 was seeking out Resident #1 and/or displaying inappropriate sexual behavior towards Resident #1 on 07/26/14, 07/28/14, 07/30/14, 08/04/14, and 08/09/14.</p> <p>Review of Resident #2's medical record revealed an admission date of 04/21/12, with diagnoses which included Diabetes, Parkinson's Disease and Dementia Without Behavioral Disturbances. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/26/14, revealed the facility assessed the resident as having a score of fifteen (15) out of fifteen (15) on the Brief Interview for Mental Status (BIMS), which indicated no cognitive impairment. Review of the Comprehensive Care Plan, revealed Resident #2 had an undated care plan for social interaction impaired related to inappropriate behavior with an intervention for every fifteen (15) minute checks dated 07/26/14.</p> <p>Even though Resident #2 was on the every fifteen (15) minute checks staff interviews revealed reports of Resident #2's behaviors continuing. Interview with LPN #2, on 08/21/14 at 1:20 PM and 09/10/14 at 9:50 AM, which revealed she was informed of an incident where Resident #2 had his/her hand under Resident #1's shirt by a SRNA on 07/28/14; Interview with SRNA #7, on 09/04/14 at 2:25 PM which revealed Resident #2 had been redirected from Resident #1's room three (3) to</p>	F 282	<p>by 8/30/14 by the Administrator and DON. All new hires in the nursing department are educated on resident care plans and the implementation of interventions during their training and orientation period.</p> <p>4. A quality assurance process is in place to audit 10% of records on a monthly basis to ensure compliance. This audit will be completed by the Director of Nursing or the Assistant director. The DON will audit 10% of records on a monthly basis to ensure compliance and identify any deficient practice. The results of this audit are made part of the facility's</p>

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four (4) times daily by her prior to him/her being sent to the hospital on 07/30/14; interview with LPN #6, on 08/29/14 at 2:45 PM, which revealed during a morning meeting on 07/30/14 another nurse came and got the Director of Nursing (DON), and the DON came back to inform the Administrator Resident #2 had been attempting to get at Resident #1 again. LPN #6 stated Resident #2 was sent to the hospital for a psych evaluation that day, 07/30/14.

Hospital record review revealed Resident #2 was admitted to the hospital's behavior unit, diagnosed with Hypersexuality, and on 08/04/14 was transferred back to the facility. Review of Resident #2's care plan revealed on 08/04/14, every fifteen (15) minute checks to be completed. However, review of the "Monitoring" forms revealed no documented evidence the every fifteen (15) minute checks were completed from 08/04/14 through 08/08/14.

Interview, on 09/04/14 at 2:25 PM, with SRNA #7 revealed she observed Resident #2 on 08/04/14 in Resident #1's room with Resident #1's pant's leg pushed up to the thigh area, and Resident #2 with his/her hand up inside the pant's leg to the groin area. Additionally, interview on 08/21/14 at 1:20 PM, with SRNA #2, revealed she observed Resident #2, on 08/04/14 in Resident #1's room with more than half of Resident #2's hand down the front of Resident #1's pants where he/she was "no doubt" touching Resident #1's "pubic area" with his/her fingers.

Interview with LPN #11 on 08/29/14 at 3:25 PM, revealed she didn't know if every fifteen (15) minutes checks were added to Resident #2's care plan or not.

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QA meeting monthly by the Clinical QA team and will continue for the next 6 months. This audit is in addition to the audit conducted daily in morning meeting which provides frequent monitoring to ensure the facility is maintaining compliance. Once a Stop and Watch tool has been initiated by a staff member, one copy is immediately given to the licensed nurse and the other copy is given to the DON for follow up and discussed in the interdisciplinary daily morning meeting. Upon completion of the assessment by the licensed nurse, any

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Interview with LPN #9 on 08/29/14 at 8:00 PM, revealed she had cared for Resident #2 "for over a year"; however, was unsure what his/her care plan interventions were.

Interview with Registered Nurse (RN) #1 on 08/29/14 at approximately 7:40 PM, revealed she was unsure what Resident #2's care plan said, however, knew from shift report she was to monitor the resident's whereabouts.

Interview, on 09/11/14 at 8:40 AM, with the MDS Coordinator revealed MDS staff reviewed and revised care plans daily, Monday through Friday, from review of Physician's Orders and information from the morning meeting. She indicated she did not recall hearing anything about the every fifteen (15) minute checks. However, the MDS Coordinator stated Resident #2's care plan noted every fifteen (15) minute checks.

Interview with the Administrator, on 08/29/14 at 6:45 PM, revealed changes in residents' conditions or behaviors were reported to all staff through every shift report. Additional interview, on 09/04/14 at 7:50 PM, with the Administrator revealed she was not certain why from 08/04/14 through 08/08/14, the every fifteen (15) minute checks for Resident #2 were not completed and documented as done per the care plan. She stated, however, the every fifteen (15) minute checks should have been completed as per the care plan. Per interview, the facility felt through the every fifteen (15) minute checks was how Resident #1 was kept safe.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14 that

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new problems, orders or interventions would be applied to the care plan. In addition, all Stop and Watch forms are discussed in the daily morning meetings to make the interdisciplinary team of possible changes in condition of residents and the need for care plan revisions. The MDS Coordinator attends the daily morning meeting and ensures compliance with the revision of resident care plans based on the information reviewed; physician's orders, incident reports, and nursing communication reports. The charge nurses complete the

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F 282	<p>Continued From page 89</p> <p>alleged removal of the IJ effective 09/03/14. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was assessed by means of a head to toe skin assessment on 07/28/14 by an LPN, and again on 08/05/14. Both skin assessments indicated Resident #1's skin was intact with no redness. A complete assessment of Resident #1 was conducted by the Physician on 07/31/14 and documented as follows: "advanced dementia, otherwise, no significant issues to deal with. Chart is reviewed. (Resident) is seen. Her exam is unchanged. Plans: for ongoing care by current written orders".</li> <li>2. After the incident on 07/26/14, Resident #2 was removed from the area and 1:1 supervision (for one hour) by activities staff was provided, followed by every 15 minute checks by nursing staff. On 08/29/14 at 9:00 PM, 1:1 monitoring was initiated, as directed by the Administrator, for Resident #2. This will be ongoing.</li> <li>3. On 08/29/14 at 9:15 PM, an in-service was conducted by the Vice President of Clinical Services for the Administrator and Director of Nursing (DON) on the following: definitions of abuse; reporting obligations related to abuse allegations; identification of abuse; investigation of abuse allegations; implementation of the facility's Resident Protection Policy; and accuracy of the clinical record. The Administrator and the DON were able to verbalize understanding of the education.</li> <li>4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30 AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and</li> </ol>	F 282	<p>daily audit process on the weekends. The results of the audit from the weekend charge nurses are reviewed by the Administrator, DON or ADON on the following work day. The Administrator has the documentation of the completion of the daily audits and the weekend audit documentation from charge nurses is forwarded to the Administrator for review. Any issues noted through this process regarding notification receives immediate followed up and the appropriate interventions/actions occur.</p> <p>5. 09-15-14</p>	
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all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.

On 08/29/14 at 10:00 PM, 08/30/14 at 10:00 AM, and 08/30/14 at 2:00 PM, all staff were in-serviced by the Administrator and the DON related to accuracy of the clinical record.

On 08/29/14 at 10:00 PM and 10:30 PM, 08/30/14 at 10:00 AM and 10:30 AM and 08/30/14 at 1:00 PM and 2:00 PM, the Administrator and the DON educated all staff on the following: the definitions of abuse; reporting obligations of abuse allegations; identification of abuse; investigation of abuse allegations and implementation of the facility's Resident Protection Policy; accuracy of the clinical record; and revision of care plans. A question and answer period was held at the conclusion of all in-services to establish competency.

Twelve (12) employees out of the facility for medical leave, maternity leave or vacation were educated by the DON via telephone. No staff will be permitted to work until they have been educated.

5. All resident records were reviewed by the DON, Minimum Data Set (MDS) staff, Admission Nurse, and administrative nurses, starting on 08/30/14 and ending on 09/02/14, to ensure accurate notification of the Physician and legal representatives. All residents who triggered on the MDS assessment for behaviors that affect others were reviewed on 08/30/14 by MDS staff and administrative nurses to ensure the care plan

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F 282 Continued From page 91

reflected current interventions. All resident assessments and care plans were reviewed by the DON, MDS staff, Admission Nurse and administrative nurses, starting on 08/30/14 and ending on 09/02/14, to ensure completeness and accuracy.

6. All female residents were questioned by the Social Service Director and the Activity Director on 08/30/14, beginning at approximately 9:30 AM, regarding whether they had been touched inappropriately by a male resident or anyone since they had resided at the facility. All residents answered "No". All male resident were interviewed by the DON and the administrative nurses on 09/02/14, beginning at approximately 10:30 AM, regarding whether they had been touched inappropriately by a male resident or anyone since they had resided at the facility. All responded "No".

7. As confirmed by Resident #2's Power of Attorney, the Charge Nurse of the facility made her aware of the initial occurrence and subsequently updated her related to Resident #2's continued persistence in propelling toward Resident #1's room. On 08/05/14 the facility Administrator met with Resident #2's POA at length to discuss future plans, room changes, etc. On 08/30/14 at 10:45 AM, the Vice President of Clinical Services met with Resident #2's POA to validate she was notified of all allegations of inappropriate behavior and actions taken by the facility.

Resident #1's son was contacted by the Vice President of Clinical Services at 4:00 PM on 08/30/14 to ensure he was aware of the above concerns. He stated he was aware and had been

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F 282 Continued From page 92  
notified by facility staff. No other concerns were expressed.

8. On 08/30/14 at 3:05 PM, the Attending Physician for Resident #1 and Resident #2 was contacted by the Vice President of Clinical Services. The Physician stated he was well aware of (Resident #2's) change in behavior. He stated he informed the surveyor he had been notified and updated concerning both residents (#1 and #2).

9. Based on the weekly skin assessments, all residents with identified skin areas were reviewed in the weekly Quality of Care meetings by the Interdisciplinary Team on 07/25/14 and 08/07/14.

A Quality Assurance process was implemented by the Administrator on 08/29/14 to monitor on a continuing basis this Allegation of Compliance through a daily monitoring meeting during which the Administrator, DON, Assistant DON, charge nurses and therapy team review Physician orders, nursing supervisor reports, 24-hour nursing communication sheets, care plan revisions, conduct daily physical rounds in the facility, review Incident reporting and ensure appropriate Physician and legal representative notifications. The daily monitoring will continue for the next three (3) months and weekly thereafter.

The facility will also utilize the Interact II Stop and Watch Program to gather input from all staff regarding any changes noted or observed with any resident's behavior or otherwise.

In the absence of the Administrator, the DON will assume the responsibility. On weekends, the

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	<p>F 282 : Continued From page 93</p> <p>Charge Nurse will complete this process.</p> <p>The DON will conduct a quality assurance audit for accuracy of clinical records on 10% of records on a monthly basis to ensure compliance.</p> <p>10. For continued monitoring of the Allegation of Compliance, a member of the governing body, either the Executive Vice President or the Vice President of Clinical Services, will be in attendance at monthly quality assurance meetings for the next three (3) months.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Copies of skin assessments, performed by licensed staff, for Resident #1 on 07/28/14 and 08/05/14 were reviewed. No concerns were revealed during this review. A review of the complete assessment by the Physician on 07/31/14 revealed no concerns.</p> <p>2. A review of every 15 minute checks of Resident #2 by nursing staff, for the period of 07/26/14 through 07/30/14, revealed no concerns. Observation of Resident #2 on 09/04/14 at 10:05 AM, revealed the resident to be sitting in the dining room with a staff member playing cards. Interview with SRNA #6 on 09/04/14 at 10:09 AM, revealed she was assigned to do 1:1 with Resident #2. Interview with the Administrator on 09/11/14 at 1:55 PM, confirmed Resident #2 was started on 1:1 monitoring on 08/29/14 and the monitoring was ongoing.</p> <p>3. The facility provided the in-service sign in sheets for training of the Administrator and the</p>	F 282	

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DON on 08/29/14, by the Vice President of Clinical Services, related to the following: accuracy of clinical records related to documentation and notification of the Physician and the POA; the definitions of abuse; identification, reporting and investigation of abuse; implementation of the facility's Protection Policy; and care plan revisions. Interview with the Administrator on 09/11/14 at 1:47 PM, and the DON on 09/11/14 at 1:35 PM, revealed both had attended the in-service training and were able to verbalize their understanding of the education.

4. The facility provided a copy of the in-service sign-in sheets for 08/29/14 and 08/30/14. Review of the records revealed training was provided for all staff regarding the following: accuracy of the clinical record; documentation and notification of the Physician and the POA; definitions of abuse; identification, reporting and investigating abuse; and revision of care plans.

Interview with SRNA #10 on 09/11/14 at 2:25 PM, revealed she had attended the in-service related to abuse. Interview with SRNA/Restorative #9, on 09/11/14 at 1:23 PM, revealed she had attended the in-service related to abuse and how to respond. Interview with the Housekeeping Supervisor on 09/11/14 at 1:30 PM, revealed she had attended the in-services related to abuse, documentation, and notification. Interview with Maintenance staff on 09/11/14 at 1:12 PM, revealed he had attended the abuse in-services. Interview with the Activity Assistant, on 09/11/14 at 1:26 PM, revealed she had received training on abuse and attended the in-service on 08/30/14. Interview with RN #2, on 09/11/14 at 1:25 PM, revealed she attended the in-service on 08/29/14 related to abuse, documentation, notification,

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F 282 Continued From page 95 reporting, identifying, investigating, and revision of care plans.

5. The facility provided a copy of audits completed, beginning 08/30/14 and ending 09/02/14, for all resident records regarding accurate notification of the Physician and the legal representative, and a review of resident assessments and care plans to ensure completeness and accuracy. Review of the audit completed on 08/30/14, related to residents who triggered on the MDS assessment for behaviors that affect others, revealed the care plans reflected current interventions. Interview with RN #2/MDS Nurse, on 09/11/14 at 1:05 PM, revealed all resident records were reviewed for documentation, Physician and POA notification, current behavior interventions, and complete and accurate assessments and care plans.

6. The facility provided interview audits completed on 08/30/14 for female residents, and on 09/02/14 for male residents, regarding whether they had been touched inappropriately by a male resident or anyone since residing at the facility. No concerns were voiced by any residents.

7. Interview with the POA for Resident #2, on 09/04/14 at 9:20 AM, revealed she had spoken with the vice President of Clinical Services and the Administrator. She confirmed she was not sure when she was first notified, but she was now aware of all allegations of inappropriate behavior on the part of Resident #2, and was aware of actions taken by the facility.

Interview with the POA for Resident #1, on 09/10/14 at 4:30 PM, revealed he had spoken with the Vice President of Clinical Services and

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F 282 Continued From page 06  
told her we was aware of the inappropriate behavior toward his mother, as he had been told by facility staff.

8. Interview with the Attending Physician for Resident #1 and Resident #2, on 09/10/14 at 5:35 PM, revealed he had spoken with the Vice President of Clinical Services and was aware of Resident #2's change in behavior.

9. Review of the Quality of Care meeting minutes revealed residents with identified skin areas were reviewed on 07/25/14 and 08/07/14. Interview with the Administrator, on 09/11/14 at 5:10 PM, revealed the team met daily to monitor care plan revisions, incident reporting, and appropriate notification of the Physician and POA. The medical record audit is scheduled to be initiated 09/17/14 and completed by the end of each month. Review of the audit tool utilized to monitor 10% of resident records for accuracy on a monthly basis revealed no concerns.

10. Interview with the Vice President of Clinical Services on 09/11/14 at 5:00 PM, revealed she or the Executive Vice President of Clinical Services would attend the monthly QA meeting for three (3) months. Monthly QA meetings are scheduled 09/17/14, 10/15/14, and 11/19/14.

F 282 F490  
It is and was on the days of survey the policy of Maysville Nursing and Rehabilitation Facility to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident.

1. The Vice President of Clinical Services for Maysville Nursing and Rehabilitation Facility provided education to the Administrator and Director of Nursing regarding implementation of the facility's policies, physician notification, updating resident care plans and maintaining clinical records. The two residents affected

F 490 483.75 EFFECTIVE  
SS=J ADMINISTRATION/RESIDENT WELL-BEING

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A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

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This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of facility's policies, it was determined the facility's Administration failed to have an effective system in place to ensure policies and procedures were implemented to ensure each resident was free from abuse and ensure care plan interventions related to supervision were implemented to prevent reoccurrence of potential abuse. The facility's failure affected two (2) of eight (8) sampled residents (Residents #1 and #2).

Interviews with nurses and State Registered Nursing Assistants (SRNAs) revealed Resident #2 was observed touching Resident #1 inappropriately on several different occasions. On 07/26/14, a visitor pointed at Resident #1 and Resident #2 and told a SRNA "you need to do something about this", as Resident #2 was observed with his/her hand inside the waist band of Resident #1's pants. On 7/28/14, Resident #2 had his/her hand under Resident's #1's shirt. On 07/30/14 sought out Resident #1, displayed inappropriate behaviors (touching inappropriately), was difficult to redirect, and was sent out to the hospital for a psychiatric (psych) evaluation. On 08/04/14, Resident #2 was readmitted and was observed on two (2) separate times that day to have more than half of his/her hand in Resident #1's pants, once near Resident #1's pubic area down the front of his/her pants and the other time in the groin area up the pant's leg. In addition, staff interviews revealed Resident #2 tried unsuccessfully on other occasions to seek out Resident #1; however, staff intervened before he/she was able to touch

F 490

by the alleged deficient practice were Resident #1 and Resident #2. Resident #1 did not exhibit any negative affects related to the inappropriate behavior of Resident #2. Resident #1 was assessed by nursing staff on 7/29/14 and 8/5/14 and by his/her physician on 7/31/14 with no issues noted and plan of care remained the same.

2. All staff (licensed and unlicensed) were in-serviced between 08-29-14 at 10:00 P.M., 08-30-14 at 10:00 A.M. and 08-30-14 at 2:00 P.M. by the Administrator and Director of Nursing covering accuracy of clinical records,

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F 490	<p>Continued From page 98</p> <p>Resident #1. On 08/09/14 at 10:40 AM Resident #2 was found in Resident #1's room again, redirected out of the room; however, continued to return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation. Interview and record review revealed the facility failed to implement policy and procedures related to abuse, revision/implementation of care plans, notification of residents' physician and responsible party, and maintaining accurate clinical records. (Refer to F-157, F-223, F-225, F-226, F-280, F-282, and F-514)</p> <p>The facility Administration's failure to have an effective system in place to ensure the policies and procedures were implemented to ensure each resident was free from abuse and to ensure care plans were revised with interventions regarding supervision were implemented was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 08/29/14 and was determined to exist on 07/26/14.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The Immediate Jeopardy was verified to be removed on 09/03/14 prior to exiting the facility on 09/11/14, with remaining non-compliance at 42 CFR 483.75, Administration, F-490 effective Administration, with a Scope and Severity of "D" while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure residents are free from abuse.</p> <p>The findings include:</p>	F 490	<p>definition of abuse, reporting obligations, identification of abuse, investigation of abuse allegations and implementing of the facility's Resident Protection Policy. There were twelve employees that were educated by the Director of Nursing via phone due to FMLA, maternity leave or vacation. - All female residents were interviewed by the Social Service Director and Activity Director on 8/30/14 as to whether they had been touched inappropriately by a male resident or anyone since residing here. All male residents were</p>

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Review of the facility's policy titled, "Abuse Investigation", undated, revealed all reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management. Per the Policy the investigation was to include interviewing the residents involved in incidents, staff members who were present at the time of the incident, the person reporting the incident, other residents, the residents' roommates, family members and visitors. The Policy revealed the investigation was to include review of documentation and the residents' medical record and review of events leading up to the incident.

Review of the facility's policy titled, "Abuse Reporting", undated, revealed the person observing an incident should immediately report it to the Charge Nurse, who was to complete an Incident Report Form and immediately examine and interview the resident. The Charge Nurse was to document his/her findings of the examination and interview in the resident's medical record and report the findings to the Administrator. Continued review of the Policy revealed upon receiving reports of abuse the Administrator or DON would immediately report the incident to the State Survey Agency, Adult Protective Services and other agencies as appropriate.

Review of the facility's policy titled, "Care Plans-Comprehensive" dated 08/01/13, revealed assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition changed. The Policy revealed the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when

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questioned by the DON and administrative nurses on 9/2/14 as to whether they had been touched inappropriately by a male resident or anyone since residing here. The answers were unanimously "no."

3. The facility is utilizing the Interact II Stop and Watch Program to gather input from all staff as to any changes noted or observed with any resident's behavior or otherwise. On 8/29/14 an in-service was conducted by the Vice President of Clinical Services for the Administrator

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the desired outcome was not met.

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and Director of Nursing covering the definitions of abuse, reporting obligations of abuse allegations and the implementation of the facility's Resident Protection Policy and accuracy of the clinical record. The Administrator and Director of Nursing were able to verbalize understanding of the education. The question and answer period at the conclusion of in services provided all staff the opportunity to ask any questions of material that wasn't clear to them. Answers were immediately given. All staff was educated on 8/29/14

Review of the facility's policy titled "Change in a Resident's Condition", dated 08/01/13, revealed the Nurse Supervisor/Charge Nurse was to notify the resident's Attending Physician or On-Call Physician when there was an incident involving the resident. Continued review of the facility policy revealed notifications of a change in condition were to be made within twenty-four (24) hours, except in the case of a medical emergency.

Review of the facility's policy titled, "Charting and Documentation" dated 08/01/13, revealed all services provided to the resident, or any changes in residents' medical or mental condition, should be documented in the resident's medical record. Further review revealed all incidents, accidents, or changes in the resident's condition must be recorded.

Interviews with facility staff revealed the Administrator was knowledgeable of Resident #2's inappropriate touching of Resident #1 since 07/26/14, when she was notified of the first incident by LPN #1/Charge Nurse. However, the Administrator failed to ensure immediate notification of Resident #1's and Resident #2's Physician and family/responsible party after the incident on 07/26/14. Staff interviews revealed Resident #2 continued to seek out Resident #1, and a total of four (4) allegations were reported to the Administrator regarding Resident #2 touching Resident #1 inappropriately. However, the Administrator failed to ensure Incident Reports regarding the incidents of alleged sexual abuse by Resident #2 were completed; failed to ensure the reporting of the alleged sexual abuse to the appropriate State Agencies; failed to ensure

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investigations were conducted after the incidents; failed to ensure Resident #1 was physically assessed for potential injury after each incident; and, failed to ensure Resident #1's and Resident #2's care plans were revised to ensure increased supervision of Resident #2 and protection for Resident #1. In addition, interviews with staff revealed the Administrator had told them not to document Resident #2's behavior in the resident's medical record.

Interview with the DON, on 08/22/14 at 10:20 AM, on 08/29/14 at 7:40 PM, at 8:00 PM and 8:30 PM, on 09/10/14 at 10:00 AM and 09/11/14 at 8:55 AM, revealed the Administrator did not instruct her or anyone else to complete and Incident Report or start an investigation related to the incidents.

Interview with the Administrator on 8/29/14 at 3:45 PM and at 6:45 PM and on 09/04/14 at 7:50 PM, revealed she was first informed of Resident #2 having "inappropriate sexual behaviors" on 07/26/14. The Administrator revealed she told LPN #1 to initiate every fifteen (15) minute checks of Resident #2. Per interview, she stated an investigation would be completed if the facility felt like there was abuse; however, she did not have staff complete an Incident Report or initiate an investigation on 07/26/14, because she did not see the incident with Resident #2 as abuse. The Administrator stated she did not have staff complete Incident Reports after any of the alleged incidents involving Resident #2, as she did not view them as reportable events. She stated she did not feel Resident #2 had acted willfully due to some reports of the resident having confusion.

Continued interview with the Administrator

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and 8/30/14 covering the accuracy of the clinical record which includes the care plan process and revisions and implementation of interventions.

4. A QA process has been implemented as of 08-29-14 by the Administrator to monitor on a continual basis, the residents' condition through daily morning meetings where the Administrator, Director of Nursing, Assistant Director of Nursing, charge nurses and therapy team review physician's orders, nursing supervisor reports, 24 hour nursing

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revealed Resident #2's Physician was updated regarding the resident's "inappropriate sexual behavior"; however, there was no documented evidence of when the Physician was first notified. The Administrator stated Resident #2's POA was first notified on 07/30/14 regarding his/her behaviors, and she had not notified Resident #1's POA of any of the alleged incidents as she had not considered them abuse. The Administrator stated she was unsure if anyone had ever notified Resident #1's POA of the alleged incidents. The Administrator revealed Resident #2 was not care planned for Hypersexuality because the diagnosis of Hypersexuality was just "taken through report" from the hospital. She stated she was not certain why the every fifteen (15) minute checks for Resident #2 were not performed and documented as completed for 08/04/14 through 08/08/14; however, stated the checks should have been completed as the facility felt that was how Resident #1 was kept safe. Per interview, it was nursing judgment whether or not to document resident behaviors, and her expectation was for documentation to be somewhere in residents' record. The Administrator stated she had not told nurses not to document in the residents' medical records.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14 that alleged removal of the IJ effective 09/03/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was assessed by means of a head to toe skin assessment on 07/28/14 by an LPN, and again on 08/05/14. Both skin assessments indicated Resident #1's skin was intact with no redness. A complete assessment of Resident #1

F 490 communication sheets and incident reports. This will ensure physician notification, care plan updates, clinical records or any allegations of verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment and involuntary seclusion are immediately reported to the Administrator, investigated and reported to the appropriate state agencies. Stop and Watch forms that are initiated and completed by staff are discussed in the daily morning meetings to make the interdisciplinary team of possible changes in

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F 490	<p>Continued From page 103</p> <p>was conducted by the Physician on 07/31/14 and documented as follows: "advanced dementia, otherwise, no significant issues to deal with. Chart is reviewed. (Resident) is seen. Her exam is unchanged. Plans: for ongoing care by current written orders".</p> <p>2. After the incident on 07/26/14, Resident #2 was removed from the area and 1:1 supervision (for one hour) by activities staff was provided, followed by every 15 minute checks by nursing staff. On 08/29/14 at 9:00 PM, 1:1 monitoring was initiated, as directed by the Administrator, for Resident #2. This will be ongoing.</p> <p>3. On 08/29/14 at 9:15 PM, an in-service was conducted by the Vice President of Clinical Services for the Administrator and Director of Nursing (DON) on the following: definitions of abuse; reporting obligations related to abuse allegations; identification of abuse; investigation of abuse allegations; implementation of the facility's Resident Protection Policy; and accuracy of the clinical record. The Administrator and the DON were able to verbalize understanding of the education.</p> <p>4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30 AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.</p> <p>On 08/29/14 at 10:00 PM, 08/30/14 at 10:00 AM, and 08/30/14 at 2:00 PM, all staff were in-serviced by the Administrator and the DON</p>	F 490	<p>condition of residents. The daily morning meetings are conducted Monday through Friday and the audits are completed by the Administrator. In the absence of the Administrator, the DON and/or ADON, or charge nurse will conduct the audits. The charge nurses complete the process on the weekends. The results of the audit from the weekend charge nurses are reviewed by the Administrator, DON or ADON on the following work day. The Administrator has the documentation of the completion of the daily audits and the weekend audit</p>

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related to accuracy of the clinical record.

On 08/29/14 at 10:00 PM and 10:30 PM, 08/30/14 at 10:00 AM and 10:30 AM and 08/30/14 at 1:00 PM and 2:00 PM, the Administrator and the DON educated all staff on the following: the definitions of abuse; reporting obligations of abuse allegations; identification of abuse; investigation of abuse allegations and implementation of the facility's Resident Protection Policy; accuracy of the clinical record; and revision of care plans. A question and answer period was held at the conclusion of all in-services to establish competency.

Twelve (12) employees out of the facility for medical leave, maternity leave or vacation were educated by the DON via telephone. No staff will be permitted to work until they have been educated.

5. All resident records were reviewed by the DON, Minimum Data Set (MDS) staff, Admission Nurse, and administrative nurses, starting on 08/30/14 and ending on 09/02/14, to ensure accurate notification of the Physician and legal representatives. All residents who triggered on the MDS assessment for behaviors that affect others were reviewed on 08/30/14 by MDS staff and administrative nurses to ensure the care plan reflected current interventions. All resident assessments and care plans were reviewed by the DON, MDS staff, Admission Nurse and administrative nurses, starting on 08/30/14 and ending on 09/02/14, to ensure completeness and accuracy.

6. All female residents were questioned by the Social Service Director and the Activity Director

F 490 documentation from charge nurses is forwarded to the Administrator for review. Any issues noted through this process regarding notification will immediately be followed up on and the appropriate actions occur. All audits will be taken to the QA committee by the Administrator reviewed by the QA committee monthly and will continue for the next 6 months.

5. 09-15-14

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on 08/30/14, beginning at approximately 9:30 AM, regarding whether they had been touched inappropriately by a male resident or anyone since they had resided at the facility. All residents answered "No". All male resident were interviewed by the DON and the administrative nurses on 09/02/14, beginning at approximately 10:30 AM, regarding whether they had been touched inappropriately by a male resident or anyone since they had resided at the facility. All responded "No".

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7. As confirmed by Resident #2's Power of Attorney, the Charge Nurse of the facility made her aware of the initial occurrence and subsequently updated her related to Resident #2's continued persistence in propelling toward Resident #1's room. On 08/05/14 the facility Administrator met with Resident #2's POA at length to discuss future plans, room changes, etc. On 08/30/14 at 10:45 AM, the Vice President of Clinical Services met with Resident #2's POA to validate she was notified of all allegations of inappropriate behavior and actions taken by the facility.

Resident #1's son was contacted by the Vice President of Clinical Services at 4:00 PM on 08/30/14 to ensure he was aware of the above concerns. He stated he was aware and had been notified by facility staff. No other concerns were expressed.

8. On 08/30/14 at 3:05 PM, the Attending Physician for Resident #1 and Resident #2 was contacted by the Vice President of Clinical Services. The Physician stated he was well aware of (Resident #2's) change in behavior. He stated he informed the surveyor he had been

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F 490 Continued From page 106 notified and updated concerning both residents (#1 and #2).

9. Based on the weekly skin assessments, all residents with identified skin areas were reviewed in the weekly Quality of Care meetings by the Interdisciplinary Team on 07/25/14 and 08/07/14.

A Quality Assurance process was implemented by the Administrator on 08/29/14 to monitor on a continuing basis this Allegation of Compliance through a daily monitoring meeting during which the Administrator, DON, Assistant DON, charge nurses and therapy team review Physician orders, nursing supervisor reports, 24-hour nursing communication sheets, care plan revisions, conduct daily physical rounds in the facility, review incident reporting and ensure appropriate Physician and legal representative notifications. The daily monitoring will continue for the next three (3) months and weekly thereafter.

The facility will also utilize the Interact II Stop and Watch Program to gather input from all staff regarding any changes noted or observed with any resident's behavior or otherwise.

In the absence of the Administrator, the DON will assume the responsibility. On weekends, the Charge Nurse will compete this process.

The DON will conduct a quality assurance audit for accuracy of clinical records on 10% of records on a monthly basis to ensure compliance.

10. For continued monitoring of the Allegation of Compliance, a member of the governing body, either the Executive Vice President or the Vice

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President of Clinical Services, will be in attendance at monthly quality assurance meetings for the next three (3) months.

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

1. Copies of skin assessments, performed by licensed staff, for Resident #1 on 07/28/14 and 08/05/14 were reviewed. No concerns were revealed during this review. A review of the complete assessment by the Physician on 07/31/14 revealed no concerns.
2. A review of every 15 minute checks of Resident #2 by nursing staff, for the period of 07/26/14 through 07/30/14, revealed no concerns. Observation of Resident #2 on 09/04/14 at 10:05 AM, revealed the resident to be sitting in the dining room with a staff member playing cards. Interview with SRNA #6 on 09/04/14 at 10:09 AM, revealed she was assigned to do 1:1 with Resident #2. Interview with the Administrator on 09/11/14 at 1:55 PM, confirmed Resident #2 was started on 1:1 monitoring on 08/29/14 and the monitoring was ongoing.
3. The facility provided the in-service sign in sheets for training of the Administrator and the DON on 08/29/14, by the Vice President of Clinical Services, related to the following: accuracy of clinical records related to documentation and notification of the Physician and the POA; the definitions of abuse; identification, reporting and investigation of abuse; implementation of the facility's Protection Policy; and care plan revisions. Interview with the Administrator on 09/11/14 at 1:47 PM, and the

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DON on 09/11/14 at 1:35 PM, revealed both had attended the in-service training and were able to verbalize their understanding of the education.

4. The facility provided a copy of the in-service sign-in sheets for 08/29/14 and 08/30/14. Review of the records revealed training was provided for all staff regarding the following: accuracy of the clinical record; documentation and notification of the Physician and the POA; definitions of abuse; identification, reporting and investigating abuse; and revision of care plans.

Interview with SRNA #10 on 09/11/14 at 2:25 PM, revealed she had attended the in-service related to abuse. Interview with SRNA/Restorative #9, on 09/11/14 at 1:23 PM, revealed she had attended the in-service related to abuse and how to respond. Interview with the Housekeeping Supervisor on 09/11/14 at 1:30 PM, revealed she had attended the in-services related to abuse, documentation, and notification. Interview with Maintenance staff on 09/11/14 at 1:12 PM, revealed he had attended the abuse in-services. Interview with the Activity Assistant, on 09/11/14 at 1:26 PM, revealed she had received training on abuse and attended the in-service on 08/30/14. Interview with RN #2, on 09/11/14 at 1:25 PM, revealed she attended the in-service on 08/29/14 related to abuse, documentation, notification, reporting, identifying, investigating, and revision of care plans.

5. The facility provided a copy of audits completed, beginning 08/30/14 and ending 09/02/14, for all resident records regarding accurate notification of the Physician and the legal representative, and a review of resident assessments and care plans to ensure

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completeness and accuracy. Review of the audit completed on 08/30/14, related to residents who triggered on the MDS assessment for behaviors that affect others, revealed the care plans reflected current interventions. Interview with RN #2/MDS Nurse, on 09/11/14 at 1:05 PM, revealed all resident records were reviewed for documentation, Physician and POA notification, current behavior interventions, and complete and accurate assessments and care plans.

6. The facility provided interview audits completed on 08/30/14 for female residents, and on 09/02/14 for male residents, regarding whether they had been touched inappropriately by a male resident or anyone since residing at the facility. No concerns were voiced by any residents.

7. Interview with the POA for Resident #2, on 09/04/14 at 9:20 AM, revealed she had spoken with the vice President of Clinical Services and the Administrator. She confirmed she was not sure when she was first notified, but she was now aware of all allegations of inappropriate behavior on the part of Resident #2, and was aware of actions taken by the facility.

Interview with the POA for Resident #1, on 09/10/14 at 4:30 PM, revealed he had spoken with the Vice President of Clinical Services and told her we was aware of the inappropriate behavior toward his mother, as he had been told by facility staff.

8. Interview with the Attending Physician for Resident #1 and Resident #2, on 09/10/14 at 5:35 PM, revealed he had spoken with the Vice President of Clinical Services and was aware of Resident #2's change in behavior.

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F 490 Continued From page 110

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9. Review of the Quality of Care meeting minutes revealed residents with identified skin areas were reviewed on 07/25/14 and 08/07/14. Interview with the Administrator, on 09/11/14 at 5:10 PM, revealed the team met daily to monitor care plan revisions, incident reporting, and appropriate notification of the Physician and POA. The medical record audit is scheduled to be initiated 09/17/14 and completed by the end of each month. Review of the audit tool utilized to monitor 10% of resident records for accuracy on a monthly basis revealed no concerns.

10. Interview with the Vice President of Clinical Services on 09/11/14 at 5:00 PM, revealed she or the Executive Vice President of Clinical Services would attend the monthly QA meeting for three (3) months. Monthly QA meetings are scheduled 09/17/14, 10/15/14, and 11/19/14.

F 514 483.75(l)(1) RES  
SS-J 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.

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F 514 It is and was on the days of survey the policy of Maysville Nursing and Rehabilitation Facility to maintain accurate, complete, and organized clinical information about each resident that is readily accessible for resident care.

1. Resident #1 and Resident #2's clinical record reflects their current care needs, plan of care and

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F 514	Continued From page 111  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 clinical records were accurate and complete to ensure documentation of alleged sexual behaviors/abuse of residents for two (2) of eight (8) sampled residents (Residents #1 and #2).  Interviews with nurses and State Registered Nursing Assistants (SRNAs) revealed Resident #2 was observed touching Resident #1 inappropriately on several different occasions. On 07/26/14, a visitor pointed at Resident #1 and Resident #2 and told a SRNA "you need to do something about this", as Resident #2 was observed with his/her hand inside the waist band of Resident #1's pants. On 7/28/14, Resident #2 had his/her hand under Resident's #1's shirt. On 07/30/14 sought out Resident #1, displayed inappropriate behaviors (touching inappropriately), was difficult to redirect, and was sent out to the hospital for a psychiatric (psych) evaluation. On 08/04/14, Resident #2 was readmitted and was observed on two (2) separate occasions that day to have more than half of his/her hand in Resident #1's pants, once near Resident #1's pubic area down the front of the resident's pants and the other time in the groin area up the resident's pant's leg. In addition, staff interviews revealed Resident #2 tried unsuccessfully on other occasions to seek out Resident #1; however, staff intervened before he/she was able to touch Resident #1. On 08/09/14 at 10:40 AM Resident #2 was found in	F 514	any behaviors/interventions noted. The facility's medical records staff and administrative nurses completed chart audit on Resident #1 and Resident #2 on 8/30/14 for completeness and accuracy. The results of the audit were forwarded to the Administrator and DON.  2. All resident records were audited for completeness by the facility's medical records staff. This audit began on 08-30-14 and concluded on 09-02-14. In addition, all resident care plans were reviewed, starting on 08-30-14 and ending on 09-02-14 by the Director of Nursing, MDS staff, Admissions nurse, and Administrative nurses

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F 514	<p>Continued From page 112</p> <p>Resident #1's room again, redirected out of the room; however, continued to return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation.</p> <p>Furthermore, interviews revealed even though nursing staff observed and reported the above alleged abuse of Resident #1 by Resident #2, they were informed by the Administrator not to document the incidents. (Refer to F-223, F-490)</p> <p>The facility's failure to have an effective system in place to ensure clinical records were accurate and complete placed residents in a situation that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was identified on 08/29/14 and was determined to exist on 07/26/14.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The Immediate Jeopardy was verified to be removed on 09/03/14 prior to exiting the facility on 09/11/14, with remaining non-compliance at 42 CFR 483.75, Administration, F-514 Clinical Records, with a Scope and Severity of "D" while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Charting and Documentation" dated 08/01/13, revealed all services provided to the resident, or any changes in residents' medical or mental condition, should</p>	F 514	<p>of completeness and accuracy.</p> <p>3. An in-service was conducted by the Vice President of Clinical Services at 9:15 P.M. on 08-29-14 for the Administrator and Director of Nursing covering the accuracy of the clinical record, that the record is readily accessible, and organized. The Administrator and Director of Nursing were able to verbalize understanding of the education. Nurses, Social Service Director, Dietary Manager, Activity Director, and licensed staff were in-serviced on the accuracy of clinical records and all staff was in-serviced related to documentation on 08-29-14 at 10:30 P.M., 08-30-</p>

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be documented in the resident's medical record. Further review revealed all incidents, accidents, or changes in the resident's condition must be recorded.

Interview with staff revealed Resident #2 was seeking out Resident #1 and/or displaying inappropriate sexual behavior towards Resident #1 on 07/26/14, 07/28/14, 07/30/14, 08/04/14, and 08/09/14.

Interview with LPN #1 on 08/22/14 at 1:00 PM, with LPN #6 on 08/25/14 at 7:30 AM, LPN #2 on 08/21/14 at 1:20 PM, and on 09/10/14 at 9:50 AM, LPN #10 on 08/21/14 at 3:20 PM, LPN #5 on 08/24/14 at 6:30 PM, revealed they were told not to document any inappropriate behavior by Resident #2. Interviews revealed when they called the Administrator, they were told by the Administrator whether to "document or not to document".

Review of Resident #1's medical record revealed the facility admitted the resident on 12/12/13, with diagnoses which included Anxiety, Dementia and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/07/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of '00' out of fifteen (15), which indicated severe cognitive impairment.

Continued review of Resident #1's medical record revealed no documented evidence of the alleged sexual abuse incident on 07/26/14, 07/28/14, or the two incidents on 08/04/14.

Review of Resident #2's medical record revealed the facility admitted the resident on 04/21/12, with diagnoses which included Parkinson's Disease,

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14 at 10:30 A.M., and 08-30-14 at 1:00 P.M. by the Administrator and Director of Nursing. This facility does not utilize agency staff. There were twelve employees that were educated by the Director of Nursing via phone due to FMLA, maternity leave or vacation. A question and answer period was held at the conclusion of all in-services to establish competency. The question and answer period at the conclusion of in services provided all staff the opportunity to ask any questions of material that wasn't clear to them. Answers were immediately provided. In addition, staff was questioned by the presenters during the in-

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Cerebrovascular Disease and Dementia Without Behavioral Disturbances. Review of the Quarterly MDS, dated 06/26/14, revealed the facility assessed Resident #2 to have a BIMS score of fifteen (15) out of fifteen (15) which indicated no cognitive impairment. Continued review of Resident #2's medical record revealed no documented evidence of the alleged sexual abuse incident on 07/26/14; or of notification of the Physician or family/responsible party of the incident. In addition, there was no documentation of the incident on 07/28/14, or the two incidents on 08/04/14.

Interview with with SRNA #8 on 09/04/14 at 2:22 PM and SRNA #7 on 09/04/14 at 2:25 PM, revealed Resident #2 continued to seek out Resident #1 and was observed going to Resident #1's room and had to be redirected away from there; however, review of the record revealed no documented evidence of this behavior in Resident #2's medical record.

Further review of Resident #2's medical record revealed the resident was readmitted on 08/04/14 from the hospital, with checks every fifteen (15) minute checks. However, review of the "Monitoring" forms revealed no documented evidence the every fifteen (15) checks were performed 08/04/14 through 08/08/14.

Interview, on 08/29/14 at 3:45 PM and 09/04/14 at 7:50 PM, with the Administrator revealed she was no sure why the every fifteen (15) minute checks were no documented; however, she indicated they should have been documented on the "Monitoring" forms as they were a part of the clinical record. Continued interview with the Administrator revealed she had not informed

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service to ensure their understanding of the materials being presented. The documentation requirements of the SRNAs in the resident clinical record are the daily Activities of Daily Living (ADL) flow sheet and bowel log. SRNAs were educated by the Administrator and DON on 8/29/14 and 8/30/14 covering the necessity of complete and accurate documentation in the clinical record. All new hires that have documentation requirements in the residents' clinical record are trained regarding complete and accurate documentation during the training and orientation period by their preceptor

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nurses not to document, and her expectation was for there to be documentation somewhere in the chart. The Administrator revealed it was up to nurses to use their nursing judgement on whether to document or not document residents' behaviors.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14 that alleged removal of the IJ effective 09/03/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was assessed by means of a head to toe skin assessment on 07/28/14 by an LPN, and again on 08/05/14. Both skin assessments indicated Resident #1's skin was intact with no redness. A complete assessment of Resident #1 was conducted by the Physician on 07/31/14 and documented as follows: "advanced dementia, otherwise, no significant issues to deal with. Chart is reviewed. (Resident) is seen. Her exam is unchanged. Plans: for ongoing care by current written orders".
2. After the incident on 07/26/14, Resident #2 was removed from the area and 1:1 supervision (for one hour) by activities staff was provided, followed by every 15 minute checks by nursing staff. On 08/29/14 at 9:00 PM, 1:1 monitoring was initiated, as directed by the Administrator, for Resident #2. This will be ongoing.
3. On 08/29/14 at 9:15 PM, an In-service was conducted by the Vice President of Clinical Services for the Administrator and Director of Nursing (DON) on the following: definitions of abuse; reporting obligations related to abuse allegations; identification of abuse; investigation

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and the Nurse Aide Coordinator.

4. A Quality Assurance process is in place to audit 10% of the current clinical records on a monthly basis to ensure compliance. The audits will be conducted by Director of Nursing or the Assistant Director of Nursing. This audit will continue for next six months. The DON will audit 10% of records on a monthly basis to ensure compliance and identify any deficient practice. The results of this audit are made part of the facility's QA meeting monthly by the Clinical QA team and will continue for the next 6 months. This audit is in addition to the audit conducted daily in morning meeting which

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F 514	<p>Continued From page 116</p> <p>of abuse allegations; implementation of the facility's Resident Protection Policy; and accuracy of the clinical record. The Administrator and the DON were able to verbalize understanding of the education.</p> <p>4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30 AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.</p> <p>On 08/29/14 at 10:00 PM, 08/30/14 at 10:00 AM, and 08/30/14 at 2:00 PM, all staff were in-serviced by the Administrator and the DON related to accuracy of the clinical record.</p> <p>On 08/29/14 at 10:00 PM and 10:30 PM, 08/30/14 at 10:00 AM and 10:30 AM and 08/30/14 at 1:00 PM and 2:00 PM, the Administrator and the DON educated all staff on the following: the definitions of abuse; reporting obligations of abuse allegations; identification of abuse; investigation of abuse allegations and implementation of the facility's Resident Protection Policy; accuracy of the clinical record; and revision of care plans. A question and answer period was held at the conclusion of all in-services to establish competency.</p> <p>Twelve (12) employees out of the facility for medical leave, maternity leave or vacation were educated by the DON via telephone. No staff will be permitted to work until they have been educated.</p>	F 514	<p>provides frequent monitoring to ensure the facility is maintaining compliance.</p> <p>5. 09-15-14</p>

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5. All resident records were reviewed by the DON, Minimum Data Set (MDS) staff, Admission Nurse, and administrative nurses, starting on 08/30/14 and ending on 09/02/14, to ensure accurate notification of the Physician and legal representatives. All residents who triggered on the MDS assessment for behaviors that affect others were reviewed on 08/30/14 by MDS staff and administrative nurses to ensure the care plan reflected current interventions. All resident assessments and care plans were reviewed by the DON, MDS staff, Admission Nurse and administrative nurses, starting on 08/30/14 and ending on 09/02/14, to ensure completeness and accuracy.

6. All female residents were questioned by the Social Service Director and the Activity Director on 08/30/14, beginning at approximately 9:30 AM, regarding whether they had been touched inappropriately by a male resident or anyone since they had resided at the facility. All residents answered "No". All male resident were interviewed by the DON and the administrative nurses on 09/02/14, beginning at approximately 10:30 AM, regarding whether they had been touched inappropriately by a male resident or anyone since they had resided at the facility. All responded "No".

7. As confirmed by Resident #2's Power of Attorney, the Charge Nurse of the facility made her aware of the initial occurrence and subsequently updated her related to Resident #2's continued persistence in propelling toward Resident #1's room. On 08/05/14 the facility Administrator met with Resident #2's POA at length to discuss future plans, room changes, etc. On 08/30/14 at 10:45 AM, the Vice President of

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F 514	<p>Continued From page 118</p> <p>Clinical Services met with Resident #2's POA to validate she was notified of all allegations of inappropriate behavior and actions taken by the facility.</p> <p>Resident #1's son was contacted by the Vice President of Clinical Services at 4:00 PM on 08/30/14 to ensure he was aware of the above concerns. He stated he was aware and had been notified by facility staff. No other concerns were expressed.</p> <p>8. On 08/30/14 at 3:05 PM, the Attending Physician for Resident #1 and Resident #2 was contacted by the Vice President of Clinical Services. The Physician stated he was well aware of (Resident #2's) change in behavior. He stated he informed the surveyor he had been notified and updated concerning both residents (#1 and #2).</p> <p>9. Based on the weekly skin assessments, all residents with identified skin areas were reviewed in the weekly Quality of Care meetings by the Interdisciplinary Team on 07/25/14 and 08/07/14.</p> <p>A Quality Assurance process was implemented by the Administrator on 08/29/14 to monitor on a continuing basis this Allegation of Compliance through a daily monitoring meeting during which the Administrator, DON, Assistant DON, charge nurses and therapy team review Physician orders, nursing supervisor reports, 24-hour nursing communication sheets, care plan revisions, conduct daily physical rounds in the facility, review incident reporting and ensure appropriate Physician and legal representative notifications. The daily monitoring will continue for the next three (3) months and weekly</p>	F 514	

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The facility will also utilize the Interact II Stop and Watch Program to gather input from all staff regarding any changes noted or observed with any resident's behavior or otherwise.

In the absence of the Administrator, the DON will assume the responsibility. On weekends, the Charge Nurse will compete this process.

The DON will conduct a quality assurance audit for accuracy of clinical records on 10% of records on a monthly basis to ensure compliance.

10. For continued monitoring of the Allegation of Compliance, a member of the governing body, either the Executive Vice President or the Vice President of Clinical Services, will be in attendance at monthly quality assurance meetings for the next three (3) months.

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

1. Copies of skin assessments, performed by licensed staff, for Resident #1 on 07/28/14 and 08/05/14 were reviewed. No concerns were revealed during this review. A review of the complete assessment by the Physician on 07/31/14 revealed no concerns.
2. A review of every 15 minute checks of Resident #2 by nursing staff, for the period of 07/26/14 through 07/30/14, revealed no concerns. Observation of Resident #2 on 09/04/14 at 10:05 AM, revealed the resident to be sitting in the dining room with a staff member playing cards. Interview with SRNA #6 on

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09/04/14 at 10:09 AM, revealed she was assigned to do 1:1 with Resident #2. Interview with the Administrator on 09/11/14 at 1:55 PM, confirmed Resident #2 was started on 1:1 monitoring on 08/29/14 and the monitoring was ongoing.

3. The facility provided the in-service sign in sheets for training of the Administrator and the DON on 08/29/14, by the Vice President of Clinical Services, related to the following: accuracy of clinical records related to documentation and notification of the Physician and the POA; the definitions of abuse; identification, reporting and investigation of abuse; implementation of the facility's Protection Policy; and care plan revisions. Interview with the Administrator on 09/11/14 at 1:47 PM, and the DON on 09/11/14 at 1:35 PM, revealed both had attended the in-service training and were able to verbalize their understanding of the education.

4. The facility provided a copy of the in-service sign-in sheets for 08/29/14 and 08/30/14. Review of the records revealed training was provided for all staff regarding the following: accuracy of the clinical record; documentation and notification of the Physician and the POA; definitions of abuse; identification, reporting and investigating abuse; and revision of care plans.

Interview with SRNA #10 on 09/11/14 at 2:25 PM, revealed she had attended the in-service related to abuse. Interview with SRNA/Restorative #9, on 09/11/14 at 1:23 PM, revealed she had attended the in-service related to abuse and how to respond. Interview with the Housekeeping Supervisor on 09/11/14 at 1:30 PM, revealed she had attended the in-services related to abuse,

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

PRINTED: 11/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/11/2014
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41066	

(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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documentation, and notification. Interview with Maintenance staff on 09/11/14 at 1:12 PM, revealed he had attended the abuse in-services. Interview with the Activity Assistant, on 09/11/14 at 1:26 PM, revealed she had received training on abuse and attended the in-service on 08/30/14. Interview with RN #2, on 09/11/14 at 1:25 PM, revealed she attended the in-service on 08/29/14 related to abuse, documentation, notification, reporting, identifying, investigating, and revision of care plans.

5. The facility provided a copy of audits completed, beginning 08/30/14 and ending 09/02/14, for all resident records regarding accurate notification of the Physician and the legal representative, and a review of resident assessments and care plans to ensure completeness and accuracy. Review of the audit completed on 08/30/14, related to residents who triggered on the MDS assessment for behaviors that affect others, revealed the care plans reflected current interventions. Interview with RN #2/MDS Nurse, on 09/11/14 at 1:05 PM, revealed all resident records were reviewed for documentation, Physician and POA notification, current behavior interventions, and complete and accurate assessments and care plans.

6. The facility provided interview audits completed on 08/30/14 for female residents, and on 09/02/14 for male residents, regarding whether they had been touched inappropriately by a male resident or anyone since residing at the facility. No concerns were voiced by any residents.

7. Interview with the POA for Resident #2, on 09/04/14 at 9:20 AM, revealed she had spoken with the vice President of Clinical Services and

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NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(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 514	<p>Continued From page 122</p> <p>the Administrator. She confirmed she was not sure when she was first notified, but she was now aware of all allegations of inappropriate behavior on the part of Resident #2, and was aware of actions taken by the facility.</p> <p>Interview with the POA for Resident #1, on 09/10/14 at 4:30 PM, revealed he had spoken with the Vice President of Clinical Services and told her we was aware of the inappropriate behavior toward his mother, as he had been told by facility staff.</p> <p>8. Interview with the Attending Physician for Resident #1 and Resident #2, on 09/10/14 at 5:35 PM, revealed he had spoken with the Vice President of Clinical Services and was aware of Resident #2's change in behavior.</p> <p>9. Review of the Quality of Care meeting minutes revealed residents with identified skin areas were reviewed on 07/25/14 and 08/07/14. Interview with the Administrator, on 09/11/14 at 5:10 PM, revealed the team met daily to monitor care plan revisions, incident reporting, and appropriate notification of the Physician and POA. The medical record audit is scheduled to be initiated 09/17/14 and completed by the end of each month. Review of the audit tool utilized to monitor 10% of resident records for accuracy on a monthly basis revealed no concerns.</p> <p>10. Interview with the Vice President of Clinical Services on 09/11/14 at 5:00 PM, revealed she or the Executive Vice President of Clinical Services would attend the monthly QA meeting for three (3) months. Monthly QA meetings are scheduled 09/17/14, 10/15/14, and 11/19/14.</p>	F 514		