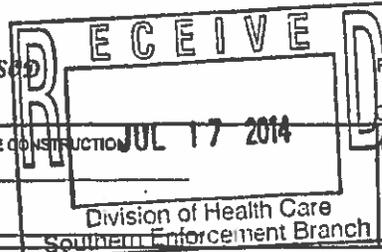


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended Survey



PRINTED: 07/15/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/04/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501
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F 000	<p>INITIAL COMMENTS</p> <p>—Amended—</p> <p>An abbreviated survey (KY21748) was initiated on 05/28/14, in conjunction with a revisit for the 02/25/14 abbreviated survey and the 04/03/14 standard survey. The complaint was substantiated. Immediate Jeopardy was identified on 05/29/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520) with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). Immediate Jeopardy was determined to exist on 05/24/14 and the facility was notified of the Immediate Jeopardy on 05/29/14.</p> <p>Interviews and review of witness statements revealed on 05/24/14, Resident #35 reported that State Registered Nurse Aide (SRNA) #3 talked mean to him/her when the resident had requested a cold, wet washcloth. (Resident #35 reported the incident the same day it occurred on 05/24/14.) Even though the facility identified the alleged perpetrator in the incident related to Resident #35 as SRNA #3, the facility allowed SRNA #3 to continue to work and provide direct care to other residents in the facility.</p> <p>In addition, review of incident reports and interviews revealed staff observed bruising to Resident #32's arm on 05/25/14. The resident reported "fat Pat grabbed" his/her arm. The facility identified the alleged perpetrator as SRNA #2. Interviews revealed SRNA #2 was suspended on 05/25/14 while the DON investigated the incident, and was allowed to</p>	F 000	<p>SHC of Pikeville takes all allegations of abuse very seriously. It has a robust policy upon which all staff have been educated, and will continue to be re-educated, as needed from time to time and on a regular basis to continually validate staff understanding of same. Pikeville staff understands that it must serve as an abuse advocate at all times for each and every resident we serve, and when abuse of any kind (e.g., physical or verbal abuse or neglect, or misappropriation of resident property) is suspected, heard, seen, or alleged by any staff member, resident, or family member, (i) to immediately protect the resident by ensuring the resident's safety (this will include the removal of the alleged perpetrator from all care areas and if an employee, suspending him/her), and (ii) to immediately take appropriate reporting action upon seeing the abusive conduct or hearing the abuse allegation. All suspicions and allegations of abuse will be reported to OIG, APS and Ombudsmen immediately, as well as other authorities as required by state law and/or as appropriate. The facility will also initiate a thorough investigation and impose appropriate discipline, as warranted.</p> <p>As outlined further below, recent training to all staff on Pikeville's abuse policy and procedure was performed and included examples of items that are state reportable: (i) any report of staff, family, or other persons being physically or verbally mean, rough, or threatening towards a resident, as well as any other statements of any kind indicating or describing such conduct — regardless of whether such conduct maybe re-defined, interpreted, or clarified by a resident as not meant to be intentional or abusive, injuries of unknown origin, withholding or taking of resident belongings, (ii) resident to resident altercations (verbal or physical), (iii) misappropriation, and/or (iv) any other resident exploitation of any kind. It also made clear that allegations of abuse are NOT to be handled, reported, or processed through the facility's grievance system ever; all must be processed and reported to the state as outlined above. Finally, all department heads will be trained on how to conduct a thorough investigation and substantiate abuse, where warranted.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn O'Conner by Eddy Strick TITLE: Administrator (X4) DATE: 7/17/14

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

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F 000	Continued From page 1 return to work and provide direct resident care on 05/28/14 after the DON stated she did not feel "like it was an allegation of abuse" because the resident reported different stories about the incident. The Administrator stated in interview conducted on 05/29/14 that he was made aware of the bruises on Resident #32's arm on 05/25/14. However, the facility's Administrator failed to ensure allegations of abuse and neglect were reported immediately to appropriate State Agencies and failed to ensure residents were protected from potential abuse while an investigation of the alleged abuse was conducted. In addition, the Administrator failed to ensure the facility's investigation included resident and staff interviews and an assessment of other residents for signs of abuse and neglect. An acceptable Allegation of Compliance was received on 06/02/14 which alleged removal of the Immediate Jeopardy on 05/31/14. A partial extended survey was conducted on 06/03/14 through 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F225 and F226.)	F 000			
F 225 SS=J	483.13(c)(1)(i)-(ii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225	1. The allegation of abuse reported by residents # 32 and 35 were reported to the Office of Inspector General by 5/28/14 by the Director of Nursing and reported to APS, Ombudsman, MD and POA by 5/30/14 by the Director of Nursing, ADDN or charge nurse. Resident # 32 and 35 have been physically assessed by a nurse and psychosocially assessed by the social services director by 5/30/14. Resident # 32 and 35 were interviewed and statement obtained by the house supervisor, director of nursing or social services director by 5/30/14. Alleged perpetrator for resident # 32 was suspended pending outcome of thorough investigation and alleged perpetrator for resident #35 is no longer employed by the facility. Thorough investigation initiated on residents #32, and 35 by 5/30/14 by the DON, ADDNs, Social services director or regional nurse consultant. All residents have been assessed for any signs and symptoms of abuse/neglect. Those residents with BIMs >8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 5/29/14. Those residents with BIMs < 8 were physically assessed by the ADDNs for any signs and symptoms of abuse/neglect along with all resident POA's contacted by social services director or chaplain to question any abuse/neglect concerns by 6/1/14. 2. An audit of all personnel records, to include any counseling, coaching, suspension and/or termination forms, was completed by the Human Resources Director and results reviewed by the Chief Nursing Executive by 5/30/14, to ensure compliance with federal and state regulations related to reporting any suspected abuse/neglect allegations and the employment of staff.	6/30/14	

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F 225	<p>Continued From page 2</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the</p>	F 225	<p>A review of all grievances and accidents/incidents from January 2014 to May 2014 was completed by DON, ADONs' SDC, MDS, by 5/30/14 to ensure all have been thoroughly investigated along with any suspected abuse/neglect identified was reported in accordance with state/federal law to ensure reporting guidelines have been met. 1 allegation was identified, reported in accordance with state/federal guidelines and thorough investigation completed.</p> <p>All residents were assessed for any suspected and/or allegations of abuse/neglect. Residents with BIMs score of > 8 were interviewed by the Social services director or chaplain by 5/30/14 for any suspected neglect issues and Residents with BIMs score of < 8 were assessed by DON, ADONs, FFN, or SDC by 5/30/14 for any s/s of suspected neglect along with residents POA's were contacted and questioned by social services director or chaplain by 5/30/14 for any suspected abuse/neglect concerns. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator, Regional Nurse Consultant or the Chief Nurse Executive by 5/30/14 for any indications of abuse/neglect concerns.</p> <p>Chart audits to include review of nurses notes, dietary notes, social services notes, quality of life notes and interdisciplinary notes were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or Regional Nurse Consultant by 5/30/14 for all residents to identify any suspected abuse/neglect allegations that have not been reported.</p> <p>3. The facility department managers, to include, administrator, DON, ADONs, SDC, MDS, wound</p>		

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F 225	<p>Continued From page 3</p> <p>facility's incident report, review of staff witness statements, and review of the facility's policy, it was determined the facility failed to ensure allegations of abuse and neglect were reported immediately to the facility's Administrator, the State Survey Agency, and other officials in accordance with State law for two (2) of three (3) sampled residents (Residents #32 and #35). The facility failed to ensure all allegations were investigated and failed to ensure residents were protected from further potential abuse during the facility's investigation.</p> <p>The facility documented on an incident report dated 05/25/14, that facility staff observed bruises to Resident #32's left wrist/forearm on 05/25/14. The resident informed staff on 05/25/14 that a nurse aide (identified by the facility as State Registered Nurse Aide #2) had "grabbed" his/her arm and "wouldn't let go." Review of the investigation revealed staff working at the time the resident's bruises were discovered was interviewed; however, other residents were not interviewed and the staff did not conduct skin assessments of other residents to determine if there were other bruises, and/or if there were other allegations of abuse until 05/28/14, three (3) days after the bruises on Resident #32's arm were observed. Further review of the investigation revealed the facility identified State Registered Nurse Aide (SRNA) #2 as the alleged perpetrator; the SRNA was suspended from resident care on 05/25/14 (the day staff observed the bruises on the resident's arm) but was allowed to return to work and provide direct resident care on 05/26/14 (two days prior to the assessments of other residents). Continued review of the investigation revealed the facility failed to notify the State Survey Agency of the</p>	F 225	<p>care nurse, BOM, QOL, maintenance director, Housekeeping director, DM, Marketing/Admissions, SSD, RSM, FFN MR and Chaplain received education from the Regional Nurse Consultant on 5/29/14 regarding the abuse/neglect policy and procedure which included - appropriately identifying any suspected abuse/neglect allegations, appropriate reporting in accordance with state/federal guidelines, ensuring safety of the residents, and conducting a thorough investigation along with the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and question and include examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident to resident altercations to include verbal or physical, and taking belongings or exploitation. Post-test was administered and 100% score obtained, if manager did not score 100% on post-test, then manager will be immediately re-educated and post-test re-administered. This process will continue until manager obtains a 100% score on post-test.</p> <p>Once the facility Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN were re-educated on the abuse policy they were then assigned to re-educate the staff on the abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements, which started on 5/29/14. No employee will be allowed to work until abuse</p>		

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F 225	<p>Continued From page 4</p> <p>allegation of abuse until 05/28/14 (three days after the bruises had been observed). The facility failed to ensure staff acted in accordance with the facility's policy that indicated, "...All allegations of abuse will be investigated and reported to the appropriate agencies...The Administrator and/or DON will notify state agencies according to their reporting guidelines. All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other official in accordance with State law through established guidelines."</p> <p>In addition, review of employee files revealed staff witness statements in SRNA #3's personnel file that alleged SRNA #3 had been verbally abusive to Resident #35. Review of a witness statement written on 05/24/14, by Licensed Practical Nurse (LPN) #2 revealed on 05/23/14, Resident #35 reported that SRNA #3 had talked mean to him/her when he/she requested a cold, wet washcloth. The facility failed to provide written documentation that staff conducted a thorough investigation. The facility's investigation did not include interviews with other residents or evidence that the allegations had been reported to the facility's Administrator and the State Survey Agency. The facility allowed SRNA #3 to provide direct resident care on 05/23/14 and 05/25/14 which was not in accordance with facility policy which stated, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..." and that "...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the</p>	F 225	<p>education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. Education regarding the abuse policy and procedure, to include identification/reporting and the Quality Assurance Performance Improvement process will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until abuse education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test.</p> <p>Staff questionnaire regarding abuse, to include the question, "What would you do if a resident told you that you were mean to them", is being administered by Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN to 10 different staff members daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating and reporting of abuse/neglect, and the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plan. Results of the staff questionnaire will be reported to the QA committee weekly for 4 weeks, starting on 5/29/14, to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will</p>		

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F 225	<p>Continued From page 5</p> <p>charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines..."</p> <p>The facility's failure to immediately report all allegations of abuse/neglect, failure to protect residents during the course of an investigation of abuse/neglect, and failure to investigate allegations of abuse/neglect caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 06/24/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520).</p> <p>An acceptable Allegation of Compliance was received on 06/02/14 which alleged removal of the Immediate Jeopardy on 05/31/14. A partial extended survey was conducted on 06/03/14 and 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F226.)</p> <p>The findings include:</p> <p>Review of the facility's policy, "Abuse, Neglect and Misappropriation," revised March 2013, revealed "...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through</p>	F 225	<p>determine at what frequency the staff questionnaire will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected Abuse/neglect was thoroughly investigated and completed along reporting guidelines are met.</p> <p>Hand in Hand training, module one, was initiated on 5/13/14 by SDC and completed on 6/4/14. There is an education calendar in which all modules have been scheduled to include all 6 modules over the next 6 months. Make up sessions will be offered until all employees have attended. New employees in orientation will receive the Hand in Hand training on a set schedule to ensure all 6 modules are completed.</p> <p>The Administrator, DON, ADONS, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFM, will be on site daily for 4 weeks to perform walking rounds in which 10 residents (five with BIMs >8 and five with BIMs <8) will be visited by the department head and interviewed regarding staff treatment for those residents that can be interviewed and for those residents who are not able to be interviewed the department heads will visit the resident, skin check will be completed by nurse as well as speak to nurse and C.N.A. regarding any noted changes in resident behaviors. The facility department heads also will interview 10 different staff members daily regarding the types of abuse, who is the abuse coordinator, when is suspected abuse reported, what would you do if a resident told you that you were mean to them etc. which began on 5/29/14. Results of resident and staff</p>	

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F 225	<p>Continued From page 6</p> <p>established guidelines..." In addition, the policy revealed, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..." The facility's policy also revealed, "...The charge nurse will immediately notify the Administrator, DON and/or Abuse Coordinator as appropriate...The Administrator and/or DON will notify state agencies according to their reporting guidelines...All allegations of abuse will be investigated and reported to the appropriate agencies...The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances..."</p> <p>1. Review of Resident #32's medical record revealed the facility admitted the resident on 12/06/13 with diagnoses which included Dementia, Alzheimer's Disease, Coronary Artery Disease, and Hypertension. Review of Resident #32's Minimum Data Set (MDS) Quarterly Assessment, dated 02/04/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident's cognition was moderately impaired.</p> <p>Review of an incident report, dated 05/25/14, revealed on 05/25/14, an SRNA called a nurse to Resident #32's room because she had observed two dark blue bruises on the resident's left wrist/forearm area. Continued review of the incident report revealed the resident stated, "Fat Pat grabbed my arm and wouldn't let it go; I had to pull myself loose."</p> <p>Interview was attempted with Resident #32 on</p>	F 225	<p>questionnaire's will be reported to the Administrator, DON, Regional Nurse Consultant or VP of Operations daily and if the Administrator is not in the facility the Department Director conducting the questionnaires will telephone the Administrator or VP of Operations the results of the resident and staff questionnaires.</p> <p>The Administrator, DON, ADDNs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN will notify Administrator of any concerns immediately regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect or misappropriation, ensuring resident is safe. A binder, which is passed on to each Department Head assigned to perform the resident and staff questionnaires daily, which contains a resident roster in which the interview date and shift is noted next to resident name to ensure that residents with BIMS >8 will be interviewed and residents with BIMS <8 will be visited, with skin checks completed, beginning on 5/29/14. The MDS Coordinators have the responsibility for updating the binder weekly to identify residents with BIMS >8 and residents with BIMS <8. If abuse, mistreatment, neglect or misappropriation is alleged during the interviews and or visits or reported by a staff member the Department Head will ensure the resident is safe, report to a charge nurse in which the charge nurse will remove the alleged perpetrator to a non-patient care area and notify the Administrator, Director of Nursing, and/or Social Services Direct/Abuse Coordinator. The alleged perpetrator will be suspended and a thorough investigation will begin immediately.</p>		

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F 225	<p>Continued From page 7</p> <p>05/28/14 at 11:10 AM. However, the resident stated, "I don't want to talk about this [s**t] anymore," and refused to provide any further information.</p> <p>Licensed Practical Nurse (LPN) #1 stated in interview conducted on 05/29/14 at 11:53 AM that she assessed Resident #32 when the bruises were identified by facility staff on 05/25/14. The LPN stated Resident #32 reported to her on 05/25/14 that "Fat Pat grabbed" his/her arm. LPN #1 identified the alleged perpetrator as SRNA #2. According to interview, LPN #1 stated she immediately notified the Director of Nursing (DON) on 05/25/14 of the resident's bruises and of Resident #32's allegation. The LPN stated the DON instructed staff to conduct a skin assessment of Resident #32, to obtain written statements from staff members that were present, and to immediately suspend the alleged perpetrator, SRNA #2. However, interview with LPN #1 revealed the DON failed to instruct her "to notify other officials in accordance with State law through established guidelines" as per the facility's policy.</p> <p>Interview with Registered Nurse (RN) #1 on 05/29/14 at 12:30 PM revealed she also assessed Resident #32 on 05/25/14, when the bruises were identified by facility staff. She further stated the alleged perpetrator had been identified, based on the resident's description, as SRNA #2. RN #1 stated she immediately notified the Administrator on 05/25/14 of the resident's bruises and the allegation of abuse. The RN further revealed the Administrator instructed her to follow the directions of the DON.</p> <p>Interview with the DON, on 05/28/14 at 4:30 PM,</p>	F 225	<p>The Administrator, Director of Nursing, Social Services or a member of regional staff will review all resident and staff questionnaires daily for any grievances/concerns and/or suspected allegations of abuse/neglect. Any suspected allegations of abuse/neglect will be immediately reported in accordance with state/federal guidelines and thorough investigations of any suspected allegations of abuse/neglect along with any grievances/concerns will be initiated upon receipt, starting on 5/30/14.</p> <p>During care plan conference for each resident any potential allegation of abuse/neglect will be discussed and education will be provided on whom to report abuse/neglect concerns by the MDS coordinator.</p> <p>The Administrator, Social Services Director or the Director of Nursing will review, daily, the grievances and incident/accident reports, starting 5/29/14, to determine if there are reportable allegations that have not been identified. Social Services Director or the Director of Nursing will report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect or misappropriation in accordance with state/federal guidelines to meet reporting requirements.</p> <p>An emergency resident council meeting was held on 5/30/14, Administrator and SDC attended, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. All residents with BIMS < 8 POA's were attempted to be contacted by Social Services Director to discuss any abuse/neglect concerns and to provide</p>		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41601		
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F 225	<p>Continued From page 8</p> <p>revealed she had been notified of the bruises to Resident #32's arm on 05/25/14 and that the resident had alleged "fat Pat" had grabbed his/her arm. The DON stated she had instructed staff to assess Resident #32, to "gather statements from staff," and to tell the alleged perpetrator not to come to work that day (05/25/14) or until the incident had been "investigated." The DON stated staff had conducted an investigation of the alleged incident on 05/25/14. However, the DON acknowledged the facility had not assessed and/or interviewed other residents, including the residents that had received direct care by SRNA #2, for signs and/or reports of abuse during the investigation. The DON stated during the facility's investigation they had only interviewed staff that worked at the facility on the day the alleged incident was reported, and had only asked the staff about the alleged incident that occurred. In addition, the DON stated that based on the facility's investigation she "didn't think it was abuse because the resident had different stories about what had happened," had investigated the incident as an injury of unknown origin, and had not notified State Agencies of the incident. However, a review of the facility's policy revealed, "All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines." The DON further stated the alleged perpetrator (SRNA #2) was permitted to return to work on 05/26/14, the day after the alleged incident was reported.</p> <p>Interview with the Administrator on 05/29/14 at 6:17 PM revealed he was notified on 05/25/14 that Resident #32 had bruises on his/her arm and</p>	F 225	<p>education on whom to report any abuse/neglect concerns without fear of retribution on 5/30/14.</p> <p>Nursing Administration (DON, ADON, Unit Manager, Staff Development Coordinator, MDS staff, facility formulary nurse, medical records, or social service director) will review documentation in the chart in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on 5 residents starting on 6/5/14. Any of the above concerns identified, the member of Nursing Administration will first ensure resident is safe by performing an assessment, notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area (if on duty) and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>Administrator will keep an abuse investigation log that will include documentation of the following: ensure resident is protected, report is filed timely, perpetrator is removed from patient care area and thorough investigation is completed. The Administrator will review the log daily as well as one of the following: Signature Care Consultant, VP of Operations, or Special Projects Administrator along with Chief Operating Officer or Chief Nursing Executive will review log for compliance weekly, starting on 6/5/14 for 4 weeks, then monthly.</p> <p>In the event of any new reports of alleged abuse, neglect or misappropriation of property, one of the following will be contacted within 24 hours and then again prior to making the final five day investigation report to OIG: Signature Care</p>		

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F 225	<p>Continued From page 9</p> <p>the resident had stated that "fat Pat grabbed" his/her arm. The Administrator stated he had not considered the resident's statement as an allegation of abuse, but as an injury of unknown origin, because the resident had "told a lot of stories" as to how the bruises occurred when questioned by facility staff. However, based on the facility's policy, "The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances." Continued interview revealed the alleged perpetrator had been instructed not to come to work on the day the incident was reported (05/25/14) but had been allowed to return to work and provide direct resident care on 05/26/14. The Administrator acknowledged the facility had not included resident assessments and interviews in their investigation, and had not reported the resident's complaint to the State Agencies.</p> <p>2. Review of Resident #35's medical record revealed the facility admitted the resident on 04/29/14 with diagnoses which included Arthritis, Chronic Obstructive Pulmonary Disease, and Diabetes. Review of the Minimum Data Set admission assessment, dated 05/15/14, revealed the facility assessed Resident #35 to have a BIMS score of 11, which indicated the resident's cognition was moderately impaired.</p> <p>Interview with Resident #35 on 05/29/14 at 9:45 AM revealed the resident had asked SRNA #3 for a cold, wet washcloth for knee pain on 05/24/14 and the SRNA told the resident he didn't have insurance like the "rest of us." Continued interview revealed SRNA #3 brought the washcloth to the resident's room, threw the washcloth to the resident, and hit the resident's</p>	F 225	<p>Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator or Chief Nursing Executive) will insure the resident is protected, report is filed timely, the perpetrator is removed from the patient care area and a thorough investigation is initiated and completed.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive or Chief Operating Officer weekly starting 6/5/14 for 4 weeks, then monthly.</p> <p>DON, ADONS, or SDC will observe the care delivery, for any suspected abuse/neglect concerns on 1 resident/unit daily (Monday through Friday) starting on 6/5/14 for 4 weeks. Any concerns noted the nursing administration will first ensure resident is safe by performing an assessment and notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>4. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive, or Chief Operating Officer, weekly for 4 weeks beginning 6/5/14, then monthly.</p>		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 225	<p>Continued From page 10</p> <p>chest with the washcloth. Further interview revealed Resident #35 reported to nursing staff that SRNA #3 talked mean to him/her. Although the resident could not recall the exact date the incident occurred, the resident reported it all happened at the same time.</p> <p>Review of a witness statement written by LPN #2, on the night shift of 05/23/14 to 05/24/14, revealed on 05/24/14, between 3:00 AM and 4:00 AM, SRNA #3 was observed walking down the hall making statements that "I hate these people; I don't know what a washcloth's going to do for [him/her]." Continued review of the witness statement revealed on 05/24/14, Resident #35 called LPN #2 to his/her room to check the resident's blood sugar and she observed the resident crying. Further review of the witness statement revealed the resident reported, "That boy that was just in here talked mean to me." The witness statement further revealed Resident #35 had asked SRNA #3 for a cold, wet washcloth for knee pain and SRNA #3 made statements to the resident that the SRNA also had knee pain but did not have insurance to see a doctor like the residents and he didn't know what a washcloth was going to do to help. Continued review of the witness statement revealed the resident was very upset and did not want SRNA #3 in his/her room again. According to the witness statement, LPN #2 contacted the on-call nurse on 05/24/14 to report the incident and was instructed to switch SRNA #3 with an SRNA from the other hall and to contact the DON. The DON was contacted and she instructed LPN #2 to place the information about the incident on the 24 Hour Report Sheet and to keep SRNA #3 out of Resident #35's room. However, the facility's policy stated, "...The charge nurse will</p>	F 225	<p>The Administrator or Signature Care Consultant will audit compliance of the above stated audits/reviews daily (M-F). Results of the audits/reviews, which include, resident interviews, resident skin checks, staff questionnaires, grievance log review, A/I review, chart documentation audits and care delivery audits will be reported to the QA committee weekly x 4 weeks to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits/reviews, along with monitoring for compliance, will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected neglect was investigated and completed along with reporting guidelines are met.</p> <p>A follow-up questionnaire will be completed by the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 different staff members daily for 4 weeks beginning 6/5/14, to ensure continued understanding regarding the abuse/neglect policy, appropriate reporting, identification, and implementing care plans to meet resident care needs.</p> <p>A Quality Assurance meeting will be held weekly for 4 weeks beginning 5/28/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue.</p>		

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F 225	<p>Continued From page 11</p> <p>Immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation.,." In addition, according to the policy, "...All allegations of abuse will be investigated and reported to the appropriate agencies..."</p> <p>LPN #2 confirmed in interview conducted on 05/29/14 at 5:09 PM that she had overheard SRNA #3 in the hall making the statement, "I hate these people, every damn one of them." Continued interview revealed the LPN was called to Resident #35's room by the resident to check the resident's blood sugar and, upon entering the resident's room, she observed Resident #36 crying. LPN #2 stated SRNA #3 had talked mean to the resident when the resident requested a cold, wet washcloth for knee pain. Further interview with LPN #2 revealed she called the DON on 05/24/14 to inform her of the incident and was told by the DON to put SRNA #3 on another hall to provide direct care, document the incident on the 24 Hour Report Sheet, and it would be investigated. However, according to the facility's policy, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..." The LPN further revealed the nursing staff from night shift "stayed over" the morning of 06/24/14 to talk with the DON about SRNA #3's negative behaviors and to turn in the witness statements about the incident.</p> <p>Review of the witness statement written by LPN #3 revealed between 3:00 AM and 3:30 AM, on</p>	F 225	The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.		

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F 225	<p>Continued From page 12</p> <p>05/24/14, SRNA #3 was observed coming out of Resident #35's room shouting, "I hate these people, every damn one of them." The witness statement further revealed Resident #35 had reportedly asked SRNA #3 for a wet washcloth and the SRNA had asked the resident why he/she needed the washcloth. Continued review of the witness statement revealed the SRNA talked hatefully to the resident and informed the resident he had knee problems for a long time and he did not have insurance like the residents and could not go to the doctor any time he wanted.</p> <p>Interview with the DON on 05/28/14 at 5:20 PM revealed the DON had been informed by facility staff by telephone on 05/24/14, that SRNA #3 had made a negative comment to Resident #35 after the resident requested a washcloth. Continued interview revealed the DON informed the caller to keep SRNA #3 out of Resident #35's room. Further interview revealed the DON talked with the night shift nurses the next morning and was informed of reports that SRNA #3 had argued with staff and had cursed in the hallway. The DON obtained witness statements from staff about the incident. The DON stated the reports were nothing she considered abusive so the incident was not investigated or reported to State Agencies. In addition, the DON acknowledged the alleged perpetrator was allowed to provide resident care after receipt of the allegation and had continued to provide resident care at the facility. However, the facility's policy revealed, "...All allegations of abuse will be investigated and reported to the appropriate agencies...remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..."</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>The Administrator stated in interview conducted on 05/29/14 that staff should have reported and investigated the allegations in accordance with facility policy. However, the Administrator stated facility staff had not made him aware of the witness statements involving SRNA #3 and Resident #35 until 05/28/14, four days after the alleged incident occurred on 05/24/14.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 06/02/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>--The allegation of abuse reported by Resident #32 was reported to the Office of Inspector General (OIG) on 05/27/14 by the DON. Resident #32 has a BIMS score greater than 8 and a statement was obtained on 05/25/14. The alleged perpetrator was suspended on 05/25/14. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the Assistant Directors of Nursing (ADONs) assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 Power of Attorneys (POAs) for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15</p>	F 225			

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F 225	<p>Continued From page 14 POAs until all have successfully been contacted.</p> <p>--The allegation of abuse related to Resident #33 that occurred on 05/24/14 was reported to OIG on 05/29/14 by the DON and reported to Adult Protective Services (APS), the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. A facility nurse assessed Resident #33 on 05/29/14 and the resident had a psychosocial assessment completed by the Social Services Director on 05/30/14. Resident #33 was interviewed and a statement was obtained by the facility's Social Services Director on 05/30/14. The alleged perpetrator was no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with a BIMS score less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>--The allegation of abuse reported by Resident #35 was reported to the Office of Inspector General on 05/29/14 by the DON and reported to APS, the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. Resident</p>	F 225			

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F 225	<p>Continued From page 15</p> <p>#35 was physically assessed by a nurse and psychosocially assessed by the Social Services Director on 05/30/14. Resident #35 was interviewed and a statement was obtained by the Social Services Director on 05/30/14. The alleged perpetrator is no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>-All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON,</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted. The Administrator, the Regional Nurse Consultant, and the Chief Nurse Executive reviewed abuse/neglect audits, assessments, interviews, and questionnaires on 05/30/14 for any indications of abuse/neglect concerns.</p> <p>—The facility's Regional Nurse Consultant from the corporate office re-educated the facility Administrator, the DON, the ADONs, the Minimum Data Set (MDS) Coordinator, the Staff Development Coordinator (SDC), the Director of Dining Services, the Business Office Manager, the Social Services Director, the Activities Director, the Chaplain, Marketing/Admissions, Medical Records, Human Resources, and Wound Care staff on 05/29/14 on the facility's abuse policy and procedure. The education included but was not limited to thorough investigations, reporting immediately, and the Quality Assurance Performance Improvement (QAPI) process, including reporting of concerns to the Administrator and floor staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and questions and included examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident-to-resident altercations to include verbal or physical, and taking belongings or exploitation. Department administrative managers were not allowed to return to work until abuse education was provided, post-tests administered, and a score of 100% obtained. If the manager did not score 100% on post-test, then the manager was immediately re-educated and re-tested. This</p>	F 225		

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F 225	Continued From page 17 process continued until all managers obtained a 100% score on the post-test. All post-tests were reviewed for compliance by the Chief Nursing Executive (CNE). —After the facility Administrator, DON, ADONs, Minimum Data Set (MDS) Coordinator, Staff Development Coordinator (SDC), Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions staff, Medical Records staff or Director, Human Relations (HR) staff, or Wound Care staff were re-educated on the abuse policy, the Administrative staff was assigned to re-educate the staff on the abuse policy and procedure which included but was not limited to reporting, protection, and investigation requirements, which started on 05/29/14. The facility did not allow any employee to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and the post-test re-administered. This process continued until all employees obtained a 100% score on the post-test. Education regarding the abuse policy and procedure, including identification/reporting and the Quality Assurance Performance Improvement process was added in the orientation process for all newly hired staff members. No newly hired employee would be allowed to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and re-tested. This process continued until employees obtained a 100% score on the post-test.	F 225			

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F 225	<p>Continued From page 18</p> <p>—Staff questionnaires regarding abuse, including the question, "What would you do if a resident told you that you were mean to them?" were administered by the Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff to five staff members on each shift and different staff members until immediacy was removed. After removal of immediacy, ten staff questionnaires were administered to staff daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating, and reporting of abuse/neglect. The questionnaire also included questions related to the QAPI process to include reporting of concerns to the Administrator and floor staff participation in development of the QAPI plan. Results of the staff questionnaire were reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of the plan. At that time, based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigation of suspected abuse/neglect was investigated/completed and reporting guidelines were met.</p> <p>—HR performed an audit of all personnel files for any abuse concerns on 05/29/14. Items that were reviewed: Coaching and Counseling forms, suspension forms, and termination forms. Results of the audit were given to the Chief Nursing Executive on 05/30/14, to review for any abuse/neglect concerns that needed reporting.</p>	F 225			

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F 225	<p>Continued From page 19</p> <p>There were no concerns identified.</p> <p>--A nurse from the facility's regional team or corporate office had been on-site since 05/29/14 and remained in the facility daily until the jeopardy was removed. The nurses from the regional team or home office assisted with investigations, observed staff treatment of residents, performed chart audits, and provided oversight and consultation. The Chief Nurse Executive, Clinical Compliance Nurse, or Director of Clinical Programs were in daily contact with the regional nurse consultant and reviewed allegations.</p> <p>--All facility grievances filed since 04/01/14 were reviewed by the Administrator, DON, or Regional Nurse Consultant on 05/30/14 to determine if any items documented were a reportable event. The Administrator was notified of one allegation of possible abuse. The Administrator reported the allegations to the Office of Inspector General on 05/30/14. The Administrator, Social Services Director, or the Director of Nursing reviewed the grievances and incident/accident reports daily, until immediacy was lifted, which was initiated on 05/29/14, to determine if there were reportable allegations that had not been identified. The Social Services Director or the Director of Nursing reported to the Administrator any identified allegations of abuse, neglect, or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect, or misappropriation to the Office of Inspector General, Adult Protective Services, and the Ombudsman.</p> <p>--An emergency resident council meeting was held on 05/30/14; the Administrator and SDC attended the meeting to discuss any</p>	F 225			

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F 225	<p>Continued From page 20</p> <p>abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. The Social Services Director attempted to contact the POAs of all residents with BIMS scores less than 8 to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution on 05/30/14.</p> <p>—The Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, and Wound Care Nurse (one per shift) were to be on-site each shift to perform walking rounds in which ten residents (five with BIMS scores greater than 8 and five with BIMS scores less than 8) were visited by the Department Head and those residents that could be interviewed were interviewed regarding the staff treatment. The Department Head visited and a nurse conducted a skin check on the residents that were not able to be interviewed. The Department Head also spoke to nursing staff and State Registered Nursing Assistants (SRNAs) regarding any noted changes in the residents' behaviors. The facility Department Head also interviewed five staff members each shift regarding the types of abuse, who the facility's Abuse Coordinator was, when to report suspected abuse, what to do if the resident reported you were mean to them, etc., which began on 05/29/14 and continued until the immediate jeopardy was lifted. Results of resident and staff questionnaires were reported to the Administrator, DON, Regional Nurse Consultant, or Vice President (VP) of Operations daily and if the Administrator was not in the facility, the Department Director conducted the</p>	F 225			

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F 225	<p>Continued From page 21</p> <p>questionnaires and telephoned the Administrator or VP of Operations with the results of the resident and staff questionnaires. This continued until the immediate jeopardy was lifted.</p> <p>—The DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff immediately notified the Administrator of any concerns regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect, or misappropriation and ensured the resident was safe. A binder (which contains a resident roster in which the interview date and shift is noted next to the resident name), which is passed on to each Department Head assigned to perform the resident and staff questionnaires each shift, to ensure that residents with BIMS scores greater than 8 were interviewed and residents with BIMS scores less than 8 were visited and skin checks completed, began on 05/29/14 and continued until the jeopardy was lifted. The MDS Coordinators had the responsibility for updating the binder weekly to identify residents with BIMS scores greater than 8 and residents with BIMS scores less than 8. If abuse, mistreatment, neglect, or misappropriation was alleged during the interviews or visits or reported by a staff member, the Department Head ensured the resident was safe, reported to a Charge Nurse, the Charge Nurse removed the alleged perpetrator to a non-patient care area, and notified the Administrator, Director of Nursing, and/or Social Services Director/Abuse Coordinator. The alleged perpetrator was suspended and an investigation began immediately.</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>—The Administrator, Director of Nursing, Social Services Director, or a member of the facility's regional staff reviewed all resident and staff questionnaires daily for any grievances/concerns. Investigations of grievances/concerns were initiated upon receipt, starting on 05/30/14.</p> <p>—Nursing Administration (DON, ADONs, Unit Managers, SDC, MDS staff, facility formulary nurse), or the Medical Records or Social Services Director, reviewed documentation in the Nursing Notes in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on ten different residents each day. If any of the above concerns were identified, the member of Nursing Administration first ensured the resident was safe by performing an assessment and then notified a Charge Nurse. The abuse policy was followed in which the alleged perpetrator was removed from a resident care area (if on duty) and the Administrator, DON, or Social Services Director was notified.</p> <p>—All resident charts were reviewed from 04/01/14 by Nursing Administration (DON, ADONs, Unit Manager, Staff Development Coordinator, MDS staff, Facility Formulary Nurse, Medical Records, Marketing/Admissions, or Social Services Director) or regional/corporate nurses by 05/30/14 for any documentation regarding abuse with no new incident being identified. Ten charts were reviewed by a member of Nursing Administration or the facility's regional or home office nurse daily to ensure that no other abuse allegations had been documented but not reported. This continued until the immediate jeopardy was removed.</p>	F 225			

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F 225	Continued From page 23 --The Administrator, Director of Nursing, and Social Services Director reviewed and discussed all abuse investigations daily to ensure that the residents were protected, the alleged perpetrator was removed from the resident care area, reports to the Office of Inspector General were filed timely, and a thorough investigation was completed. The Administrator maintained an abuse investigation log that included documentation of the following: ensured protection of residents, removed perpetrator from resident care area, reports to the Office of Inspector General filed timely, and thorough investigations completed. The Administrator and one of the following, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant, reviewed the abuse investigation to ensure protection of the resident; that the perpetrator was removed from the resident care area; that reports to the Office of Inspector General were filed timely; and that a thorough investigation had been completed. This will occur daily until removal of immediate jeopardy. --For new reports of alleged abuse, neglect, or misappropriation of property, after the immediate jeopardy was removed, one of the following was contacted prior to making the final five-day investigation report to OIG: Signature Care Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator, or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or Chief Nursing Executive) ensured the resident was protected, report was filed timely, the perpetrator was removed from the patient care area, and a thorough investigation was completed.	F 225			

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F 225	Continued From page 24 --With any new report of alleged abuse, neglect, or misappropriation of property, one of the following was contacted within 24 hours to review the abuse investigation to ensure that a thorough investigation was completed and reporting timelines were met: Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or CNE. --All incident reports from January 2014 to 03/29/14 were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any concerns of suspected neglect by 05/30/14. None was identified. --During care plan conference for each resident, any abuse/neglect concerns were discussed and abuse/neglect education, to include reporting, was provided to the resident and/or POA with supporting documentation noted. --Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the CEO daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly. --The DON, ADONs, or SDC observed the care delivery for any suspected abuse/neglect concerns on five residents daily until the removal of immediacy and then weekly (Monday through Friday). The results of the care delivery audits were reported to the QA Committee weekly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA Committee would	F 225			

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F 225	<p>Continued From page 25</p> <p>determine at what frequency the audits needed to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigations of suspected abuse/neglect were investigated/completed and reporting guidelines were met.</p> <p>—A Quality Assurance meeting was held weekly for four weeks beginning 05/29/14, then monthly for recommendations and further follow-up regarding the above stated plan. At that time, based upon evaluation, the QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting was to be completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the Chief Executive Officer (CEO) daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interviews with Administrative Staff revealed the allegation involving Resident #32 was investigated and reported to the appropriate State agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any</p>	F 225			

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F 225	<p>Continued From page 26 concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation involving Resident #33 was investigated and reported to the appropriate state agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation that involved Resident #35 was investigated and reported to the appropriate state agency. The investigation included interviews with Resident #35, staff, and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's assessments for signs and symptoms of abuse and resident interviews revealed the facility completed them on 05/29/14. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed as of 06/03/14, only six POAs had not been contacted so the facility sent the abuse/neglect questionnaire by certified mail to the POAs. A review of the abuse/neglect assessments, abuse/neglect audits, and abuse/neglect interviews revealed the Administrative staff provided validation and oversight.</p> <p>Review of Administrative staff education and testing, provided on 05/29/14, related to</p>	F 225			

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F 225	<p>Continued From page 27</p> <p>abuse/neglect policy, investigations, reporting, and the Quality Assessment process was reviewed and validated by the Chief Nursing Executive (CNE).</p> <p>Review of staff education and post-testing related to the abuse policy and procedure which included reporting, protection, and investigation requirements revealed the education was provided on 05/29/14, as per the AOC. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM, revealed during the staff in-service examples were given of different situations of abuse/neglect and the staff had to explain the appropriate actions. Further interview with the Regional Nurse Consultant revealed the facility had not hired any new employees.</p> <p>A review of the staff questionnaire regarding abuse was being done as reported in the AOC. Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed no issues had been identified through the staff questionnaires.</p> <p>Review of the HR Audits of personnel files revealed the CNE validated review by signature on the back of the audit forms. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed there were no issues identified with the review of the employee files.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed a corporate staff member had been at the facility since the jeopardy was identified and had been reviewing all allegations to ensure a thorough investigation was conducted. Further interview revealed the corporate staff was also conducting chart audits,</p>	F 225			

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F 225	<p>Continued From page 28</p> <p>observed staff treatment of residents, and provided consultation.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed all facility grievances filed since 04/01/14 were reviewed for possible allegations of abuse/neglect. The interview revealed one grievance was related to cigarettes that were missing. The incident was investigated with no concerns identified. Continued interview revealed the facility's smoking policy had recently been updated to account for all residents' cigarettes.</p> <p>Interviews on 06/04/14 with the Regional Nurse Consultant and SDC revealed a Resident Council meeting was held on 05/30/14 to discuss abuse/neglect concerns and education was provided on reporting abuse/neglect concerns without fear of retribution. The interview further revealed residents that did not attend the meeting were also provided education related to reporting abuse.</p> <p>Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed as of 05/29/14 a daily census was completed and residents were chosen by the Administrator to be interviewed and to observe staff as they provided care to the resident which was done by Administrative Staff. The interview further revealed staff providing care to residents with a BIMS score less than 8 were interviewed about changes in the resident. The Administrator or a member of the regional team validated the interviews and observations of care were completed.</p> <p>Interview on 06/04/14 with the Regional Nurse</p>	F 225			

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F 225	<p>Continued From page 29</p> <p>Consultant and the Administrator revealed a binder with all questionnaires related to abuse/neglect was passed to each Department Head assigned to distribute the questionnaires. The interview further revealed the staff had notified the Administrator with the results of the questionnaires. A review of the binder revealed no issues were identified. The binder contained a resident roster which included the dates and shifts the residents had been interviewed or assessed. The binder had been updated as BIMS scores changed. There were no issues identified during the interviews.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed the Administrator or regional team member had reviewed all questionnaires with no issues identified. A review of the questionnaires revealed a signature validated the questionnaires had been reviewed.</p> <p>Interview with Administrative Nursing Staff on 06/04/14 revealed resident charts had been reviewed each day for entries in the Nurse's Notes that could be related to abuse or neglect.</p> <p>Interview on 06/04/14 with Administrative Nursing Staff revealed all resident charts had been audited from 04/01/14 for any documentation regarding abuse and no new concerns were identified. The interviews revealed ten charts continued to be reviewed daily for any new documented evidence of abuse that was not reported.</p> <p>Interview on 06/04/14 with Administrative Staff and the Regional Nurse Consultant revealed all abuse investigations had been discussed and</p>	F 225			

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F 225	<p>Continued From page 30</p> <p>reviewed daily to ensure the facility's abuse policy was followed to ensure the resident was protected, the perpetrator was removed from the resident care area, the incident was reported timely, and an investigation was completed. Further interview revealed the Administrator maintained an abuse log to ensure all areas of the investigations were completed. Continued interviews revealed the Administrator and one corporate staff member reviewed investigations to ensure they were complete.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed after the Immediate Jeopardy was removed new reports of alleged abuse investigations will be reviewed by a Corporate Staff Member prior to the five-day report being sent to OIG. The Corporate Staff member will ensure the resident was protected, the incident was reported timely, the perpetrator was removed from patient care area, and a thorough investigation was completed.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed new reports of abuse or neglect will be reported to a Corporate Staff Member within 24 hours to ensure an investigation was completed and the reporting timelines were met.</p> <p>Interviews on 06/04/14 with Administrative Nursing Staff and the Regional Nurse Consultant revealed all incident reports that had been completed since January 2014 were reviewed for concerns related to abuse/neglect and none were identified.</p> <p>Interview on 06/04/14 with the MDS Coordinator revealed questions about concerns related to</p>	F 225			

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F 225	<p>Continued From page 31</p> <p>abuse/neglect and education about reporting abuse/neglect were added to the care plan conferences. The interview further revealed resident family members that attended the care plan conferences were questioned about abuse/neglect concerns in the facility and educated on how to report an abuse/neglect concern.</p> <p>Interviews on 06/04/14 with the Administrator and the Regional Nurse Consultant revealed administrative oversight was completed weekly and will continue monthly after the Immediate Jeopardy was removed.</p> <p>Interviews on 06/04/14 with the DON, ADON, and SDC revealed observation of staff as they provided care was completed for any suspected abuse/neglect concerns on a daily basis for five residents and will continue weekly after the removal of the Immediate Jeopardy. Continued interviews revealed the reports were reported to the QA Committee to determine the need for additional education concerns or change of the plan.</p> <p>Interviews on 06/04/14 with Administrative Staff revealed a Quality Assurance meeting had been held weekly beginning 05/29/14 and will be held weekly for four weeks and then monthly. The interviews further revealed evaluations by the Committee would determine the frequency and length of ongoing audits. Further interviews revealed corporate oversight had been in place since 05/29/14, on a daily basis, until the Immediate Jeopardy was removed and will continue weekly for four weeks and then will continue monthly.</p>	F 225			

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F 226 F 228 SS=J	Continued From page 32 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's incident report, review of staff witness statements, and review of the facility's policy, "Abuse, Neglect and Misappropriation," revised March 2013, it was determined the facility failed to ensure policies that prohibited abuse were implemented for two (2) of thirty-five (35) sampled residents (Residents #32 and #35). The facility failed to ensure staff implemented its policy and immediately reported allegations of abuse to the facility's Administrator, the State Survey Agency, and other officials in accordance with State law, failed to ensure all allegations were investigated, and failed to ensure residents were protected from further potential abuse during the facility's investigation. Review of incident reports and interviews revealed on 05/25/14, staff observed bruising to Resident #32's arm. The resident reported to staff on 05/25/14 that "fat Pat grabbed" his/her arm (Resident #32 reported the incident the same day it occurred). The facility identified the alleged perpetrator as State Registered Nurse Aide (SRNA) #2. Interviews revealed the Director of Nursing (DON) initiated an investigation and SRNA #2 was suspended on 05/25/14 during the	F 226 F 228	F-226 1. The allegation of abuse reported by residents # 32 and 35 were reported to the Office of Inspector General by 5/29/14 by the Director of Nursing and reported to APS, Ombudsman, MD and POA by 5/30/14 by the Director of Nursing, ADON or charge nurse. Resident # 32 and 35 have been physically assessed by a nurse and psychosocially assessed by the social services director by 5/30/14. Resident # 32 and 35 were interviewed and statement obtained by the house supervisor, director of nursing or social services director by 5/30/14. Alleged perpetrator for resident # 32 was suspended pending outcome of thorough investigation and alleged perpetrator for resident #35 is no longer employed by the facility. Thorough investigation initiated on residents #32, and 35 by 5/30/14 by the DON, ADONs, Social services director or regional nurse consultant. All residents have been assessed for any signs and symptoms of abuse/neglect. Those residents with BIMs >8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 5/29/14. Those residents with BIMs < 8 were physically assessed by the ADONs for any signs and symptoms of abuse/neglect along with all resident POA's contacted by social services director or chaplain to question any abuse/neglect concerns by 6/1/14. 2. An audit of all personnel records, to include any counseling, coaching, suspension and/or termination forms, was completed by the Human Resources Director and results reviewed by the Chief Nursing Executive by 5/30/14, to ensure compliance with federal and state regulations related to reporting any suspected abuse/neglect allegations and the employment of staff.	6/30/14	

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F 226	<p>Continued From page 33</p> <p>Investigation. The DON stated she didn't feel "like it was an allegation of abuse" because the resident reported different stories about the incident; SRNA #2 was allowed to return to work to provide direct resident care on 05/28/14. However, the facility failed to follow its policies which stated, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation ...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines..."</p> <p>In addition, interviews and review of witness statements revealed on 05/24/14, Resident #35 reported State Registered Nurse Aide (SRNA) #3 talked mean to him/her when the resident requested a cold, wet washcloth. The facility received reports that identified the alleged perpetrator in the incident related to Resident #35 as State Registered Nurse Aide #3; however, the facility did not implement its policy. The facility's policy stated, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..." The facility allowed SRNA #3 to continue to provide care to other residents in the facility after the allegations were made.</p> <p>The facility's failure to implement its policies and procedures that prohibited neglect, mistreatment, and abuse that included reporting allegations of</p>	F 226	<p>A review of all grievances and accidents/incidents from January 2014 to May 2014 was completed by DON, ADONs' SDC, MDS, by 5/30/14 to ensure all have been thoroughly investigated along with any suspected abuse/neglect identified was reported in accordance with state/federal law to ensure reporting guidelines have been met. 1 allegation was identified, reported in accordance with state/federal guidelines and thorough investigation completed.</p> <p>All residents were assessed for any suspected and/or allegations of abuse/neglect. Residents with BIMS score of > 8 were interviewed by the Social services director or chaplain by 5/30/14 for any suspected neglect issues and Residents with BIMS score of < 8 were assessed by DON, ADONs, FFN, or SDC by 5/30/14 for any s/s of suspected neglect along with residents PDA's were contacted and questioned by social services director or chaplain by 5/30/14 for any suspected abuse/neglect concerns. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator, Regional Nurse Consultant or the Chief Nurse Executive by 5/30/14 for any indications of abuse/neglect concerns.</p> <p>Chart audits to include review of nurses notes, dietary notes, social services notes, quality of life notes and interdisciplinary notes were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or Regional Nurse Consultant by 5/30/14 for all residents to identify any suspected abuse/neglect allegations that have not been reported.</p> <p>The facility department managers, to include, administrator, DON, ADONs, SDC, MDS, wound</p>		

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F 226	<p>Continued From page 34</p> <p>abuse, protecting residents during the course of the investigation, and conducting an investigation of an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/24/14 at 42 CFR 483 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520).</p> <p>An acceptable Allegation of Compliance was received on 06/02/14, which alleged removal of the Immediate Jeopardy on 05/31/14. A partial extended survey was conducted on 06/03/14 through 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14, as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F225.)</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Abuse, Neglect and Misappropriation," revised March 2013 revealed "All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines." In addition, the policy revealed, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the</p>	F 226	<p>care nurse, BOM, QOI, maintenance director, Housekeeping director, DM, Marketing/Admissions, SSD, RSM, FFN M/R and Chaplain received education from the Regional Nurse Consultant on 5/29/14 regarding the abuse/neglect policy and procedure which included - appropriately identifying any suspected abuse/neglect allegations, appropriate reporting in accordance with state/federal guidelines, ensuring safety of the residents, and conducting a thorough investigation along with the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and question and include examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident to resident altercations to include verbal or physical, and taking belongings or exploitation. Post-test was administered and 100% score obtained, if manager did not score 100% on post-test, then manager will be immediately re-educated and post-test re-administered. This process will continue until manager obtains a 100% score on post-test.</p> <p>Once the facility Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN were re-educated on the abuse policy they were then assigned to re-educate the staff on the abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements, which started on 5/29/14. No employee will be allowed to work until abuse</p>		

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F 226	<p>Continued From page 35</p> <p>investigation..." The policy revealed, "...The charge nurse will immediately notify the Administrator, DON and/or Abuse Coordinator as appropriate...The Administrator and/or DON will notify state agencies according to their reporting guidelines..." In addition, according to the policy, "...All allegations of abuse will be investigated and reported to the appropriate agencies...The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances..." Continued review of the policy revealed under section II, "Training/Identification/Prevention," staff is trained to identify "...Signs & Symptoms of abuse (bruises, injuries of unknown origin, crying, fearful, increased agitation, and withdrawal)..." as part of their orientation.</p> <p>1. The facility admitted Resident #32 on 12/06/13 with diagnoses which included Dementia, Alzheimer's Disease, Coronary Artery Disease, and Hypertension. Review of Resident #32's Minimum Data Set (MDS) Quarterly Assessment, dated 02/04/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired.</p> <p>Review of an incident report, dated 05/25/14 revealed staff observed two bruises to Resident #32's arm. The resident told staff, "Fat Pat grabbed my arm and wouldn't let it go; I had to pull myself loose." The facility identified the alleged perpetrator as SRNA #2. Facility staff immediately notified the Director of Nursing (DON) of the bruises to Resident #32's arm and was instructed to conduct a skin assessment for Resident #32, obtain witness statements from all staff present, and SRNA #2 was to be</p>	F 226	<p>education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. Education regarding the abuse policy and procedure, to include identification/reporting and the Quality Assurance Performance Improvement process will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until abuse education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test.</p> <p>Staff questionnaire regarding abuse, to include the question, "What would you do if a resident told you that you were mean to them", is being administered by Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN to 10 different staff members daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating and reporting of abuse/neglect, and the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plan. Results of the staff questionnaire will be reported to the QA committee weekly for 4 weeks, starting on 5/29/14, to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will</p>		

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F 226	<p>Continued From page 36 suspended.</p> <p>The DON acknowledged in interview conducted on 05/28/14 at 4:30 PM that staff had not interviewed other residents for which SRNA #2 had provided direct care for signs of abuse and the only staff interviews conducted were from staff working when the alleged incident occurred, and the interviews were related only to the alleged incident. According to the DON, the incident was investigated on 05/25/14, and she "didn't think it was abuse, because the resident had different stories about what had happened." Interview and review of the investigation revealed the facility failed to ensure staff acted in accordance with the facility's policy to ensure that "...The Administrator and/or DON will notify state agencies according to their reporting guidelines...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..."</p> <p>The Administrator stated in interview conducted on 05/29/14 at 6:17 PM that staff had notified him of the bruises to Resident #32's arm and he had instructed staff to follow the directions given by the DON. The Administrator stated he had not considered the resident's statement as an allegation of abuse but as an injury of unknown origin because the resident had "told a lot of stories" as to how the bruises occurred. Further interview revealed he had not reported the incident to the State Agencies. The Administrator acknowledged staff had not conducted assessments/interviews with other residents during the course of the facility's investigation in</p>	F 226	<p>determine at what frequency the staff questionnaire will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected Abuse/neglect was thoroughly investigated and completed along reporting guidelines are met.</p> <p>Hand in Hand training, module one, was initiated on 5/13/14 by SDC and completed on 6/4/14. There is an education calendar in which all modules have been scheduled to include all 6 modules over the next 6 months. Make up sessions will be offered until all employees have attended. New employees in orientation will receive the Hand in Hand training on a set schedule to ensure all 6 modules are completed.</p> <p>The Administrator, DON, ADONS, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN, will be on site daily for 4 weeks to perform walking rounds in which 10 residents (five with BIMs >8 and five with BIMs <8) will be visited by the department head and interviewed regarding staff treatment for those residents that can be interviewed and for those residents who are not able to be interviewed the department heads will visit the resident, skin check will be completed by nurse as well as speak to nurse and C.N.A. regarding any noted changes in resident behaviors. The facility department heads also will interview 10 different staff members daily regarding the types of abuse, who is the abuse coordinator, when is suspected abuse reported, what would you do if a resident told you that you were mean to them etc. which began on 5/29/14. Results of resident and staff</p>		

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F 226	<p>Continued From page 37</p> <p>an effort to identify other residents that might exhibit signs/symptoms of abuse. However, review of the facility's policy, revealed staff was trained to identify "...Signs & Symptoms of abuse (bruises, injuries of unknown origin, crying; fearful, increased agitation, and withdrawal)..." as part of their orientation.</p> <p>2. Review of Resident #35's medical record revealed the facility admitted the resident on 04/29/14, with diagnoses which included Arthritis, Chronic Obstructive Pulmonary Disease, and Diabetes. The facility assessed the resident to have a BIMS score of 11, which indicated the resident's cognition was moderately impaired.</p> <p>Review of SRNA #3's personnel files revealed a witness statement that indicated on 05/24/14, Licensed Practical Nurse (LPN) #2 had observed the SRNA between 3:00 AM and 4:00 AM on 05/24/14 walking down the hall making the statement, "I hate these people; I don't know what a washcloth's going to do for [him/her]." Continued review of the witness statement revealed at that time on 05/24/14, Resident #35 requested LPN #2 to check his/her blood sugar and the LPN observed the resident crying. The statement revealed on 05/24/14, Resident #35 informed the nurse, "That boy that was just in here talked mean to me." According to documentation on the witness statement, Resident #35 had asked SRNA #3 for a cold, wet washcloth for knee pain and SRNA #3 informed the resident he had knee pain but did not have insurance to see a doctor like the residents. The resident reported the SRNA stated, "I don't know what a wet washcloth's going to do for your leg pain." Continued review of the witness statement revealed the resident was very upset and did not</p>	F 226	<p>questionnaire's will be reported to the Administrator, DON, Regional Nurse Consultant or VP of Operations daily and if the Administrator is not in the facility the Department Director conducting the questionnaires will telephone the Administrator or VP of Operations the results of the resident and staff questionnaires.</p> <p>The Administrator, DON, ADONs, MDS coordinator, SOC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN will notify Administrator of any concerns immediately regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect or misappropriation, ensuring resident is safe. A binder, which is passed on to each Department Head assigned to perform the resident and staff questionnaires daily, which contains a resident roster in which the interview date and shift is noted next to resident name to ensure that residents with BIMS >8 will be interviewed and residents with BIMS <8 will be visited, with skin checks completed, beginning on 5/29/14. The MDS Coordinators have the responsibility for updating the binder weekly to identify residents with BIMS >8 and residents with BIMS <8. If abuse, mistreatment, neglect or misappropriation is alleged during the interviews and or visits or reported by a staff member the Department Head will ensure the resident is safe, report to a charge nurse in which the charge nurse will remove the alleged perpetrator to a non-patient care area and notify the Administrator, Director of Nursing, and/or Social Services Direct/Abuse Coordinator. The alleged perpetrator will be suspended and a thorough investigation will begin immediately.</p>		

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F 226	<p>Continued From page 38</p> <p>want SRNA #3 in his/her room again. Further review of the witness statement revealed LPN #2 contacted the on-call nurse to report the incident and was instructed to switch SRNA #3 with a resident from the other hall and to contact the DON. The LPN contacted the DON on 05/24/14, and was instructed by the DON to place the information about the incident on the 24-hour report sheet and to keep SRNA #3 out of Resident #35's room. However, there was no documented evidence that staff was instructed to follow and/or followed the facility's policy and "...immediately remove[d] the suspected perpetrator from resident care areas, obtain[ed] the staff members witness statement and immediately suspend[ed] the employee pending the outcome of the investigation...", or that the allegation of abuse had been "...investigated and reported to the appropriate agencies..." in accordance with facility policy.</p> <p>Interview with LPN #2 on 05/29/14 at 5:09 PM revealed the LPN called the DON on 05/24/14 to inform her of the incident and was told by the DON to put SRNA #3 on another hall to work and put the incident on the 24-hour report sheet to be investigated. However, the DON failed to direct the LPN to follow the facility's policy which stated, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation...All allegations of abuse will be investigated and reported to the appropriate agencies..." Continued interview with LPN #2 revealed when the DON came to the facility on 05/24/14, nursing staff from the night shift informed the DON of SRNA #3's negative behaviors and provided the DON witness</p>	F 226	<p>The Administrator, Director of Nursing, Social Services or a member of regional staff will review all resident and staff questionnaires daily for any grievances/concerns and/or suspected allegations of abuse/neglect. Any suspected allegations of abuse/neglect will be immediately reported in accordance with state/federal guidelines and thorough investigations of any suspected allegations of abuse/neglect along with any grievances/concerns will be initiated upon receipt, starting on 5/30/14.</p> <p>During care plan conference for each resident any potential allegation of abuse/neglect will be discussed and education will be provided on whom to report abuse/neglect concerns by the MDS coordinator.</p> <p>The Administrator, Social Services Director or the Director of Nursing will review, daily, the grievances and incident/accident reports, starting 5/29/14, to determine if there are reportable allegations that have not been identified. Social Services Director or the Director of Nursing will report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect or misappropriation in accordance with state/federal guidelines to meet reporting requirements.</p> <p>An emergency resident council meeting was held on 5/30/14, Administrator and SDC attended, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. All residents with BIMs < 8 POA's were attempted to be contacted by Social Services Director to discuss any abuse/neglect concerns and to provide</p>		

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F 226	<p>Continued From page 39</p> <p>statements about the incident that had been reported on 05/24/14.</p> <p>The DON acknowledged in interview conducted on 05/28/14 at 5:20 PM that staff had notified her on 05/24/14 of the incident related to SRNA #3 and Resident #35. The DON stated she had informed staff to keep SRNA #3 out of Resident #35's room. Further interview revealed the DON talked with the night shift nurses the next morning, was informed of reports that SRNA #3 had argued with staff and cursed in the hallway, and was given the staff's witness statements about the incident. The DON stated the reports were nothing she considered abusive so the incident was not investigated or reported.</p> <p>Interview with the Administrator on 05/29/14 at 6:17 PM revealed the Administrator was not made aware of the incident or of the witness statements involving SRNA #3 and Resident #35 until 06/28/14. Continued interview revealed the Administrator revealed the allegations should have been investigated and reported per the facility's policy.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 06/02/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>—The allegation of abuse reported by Resident #32 was reported to the Office of Inspector General (OIG) on 05/27/14 by the DON. Resident #32 has a BIMS score greater than 8 and a statement was obtained on 05/26/14. The alleged perpetrator was suspended on 05/25/14. The facility's investigation was initiated and ongoing with a five-day report to be submitted to</p>	F 226	<p>education on whom to report any abuse/neglect concerns without fear of retribution on 5/30/14.</p> <p>Nursing Administration (DON, ADON, Unit Manager, Staff Development Coordinator, MDS staff, facility formulary nurse, medical records, or social service director) will review documentation in the chart in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on 5 residents starting on 6/5/14. Any of the above concerns identified, the member of Nursing Administration will first ensure resident is safe by performing an assessment, notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area (if on duty) and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>Administrator will keep an abuse investigation log that will include documentation of the following: ensure resident is protected, report is filed timely, perpetrator is removed from patient care area and thorough investigation is completed. The Administrator will review the log daily as well as one of the following: Signature Care Consultant, VP of Operations, or Special Projects Administrator along with Chief Operating Officer or Chief Nursing Executive will review log for compliance weekly, starting on 6/5/14 for 4 weeks, then monthly.</p> <p>In the event of any new reports of alleged abuse, neglect or misappropriation of property, one of the following will be contacted within 24 hours and then again prior to making the final five day investigation report to OIG: Signature Care</p>	

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F 226	<p>Continued From page 40</p> <p>OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the Assistant Directors of Nursing (ADONs) assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 Power of Attorneys (POAs) for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted.</p> <p>—The allegation of abuse related to Resident #33 that occurred on 05/24/14 was reported to OIG on 05/29/14 by the DON and reported to Adult Protective Services (APS), the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. A facility nurse assessed Resident #33 on 05/29/14 and the resident had a psychosocial assessment completed by the Social Services Director on 05/30/14. Resident #33 was interviewed and a statement was obtained by the facility's Social Services Director on 05/30/14. The alleged perpetrator was no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical</p>	F 226	<p>Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator or Chief Nursing Executive) will insure the resident is protected, report is filed timely, the perpetrator is removed from the patient care area and a thorough investigation is initiated and completed.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive or Chief Operating Officer weekly starting 6/5/14 for 4 weeks, then monthly.</p> <p>DON, ADONs, or SDC will observe the care delivery, for any suspected abuse/neglect concerns on 1 resident/unit daily (Monday through Friday) starting on 6/5/14 for 4 weeks. Any concerns noted the nursing administration will first ensure resident is safe by performing an assessment and notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>4. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive, or Chief Operating Officer, weekly for 4 weeks beginning 6/5/14, then monthly.</p>		

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F 226	<p>Continued From page 41</p> <p>status of residents with a BIMS score less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>--The allegation of abuse reported by Resident #35 was reported to the Office of Inspector General on 05/29/14 by the DON and reported to APS, the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. Resident #35 was physically assessed by a nurse and psychosocially assessed by the Social Services Director on 05/30/14. Resident #35 was interviewed and a statement was obtained by the Social Services Director on 05/30/14. The alleged perpetrator is no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt</p>	F 226	<p>The Administrator or Signature Care Consultant will audit compliance of the above stated audits/reviews daily (M-F). Results of the audits/reviews, which include, resident interviews, resident skin checks, staff questionnaires, grievance log review, A/I review, chart documentation audits and care delivery audits will be reported to the QA committee weekly x 4 weeks to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits/reviews, along with monitoring for compliance, will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected neglect was investigated and completed along with reporting guidelines are met.</p> <p>A follow-up questionnaire will be completed by the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplain, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 different staff members daily for 4 weeks beginning 6/5/14, to ensure continued understanding regarding the abuse/neglect policy, appropriate reporting, identification, and implementing care plans to meet resident care needs.</p> <p>A Quality Assurance meeting will be held weekly for 4 weeks beginning 5/28/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue.</p>		

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F 226	<p>Continued From page 42</p> <p>to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>--All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted. Tho Administrator, the Regional Nurse Consultant, and the Chief Nurse Executive reviewed abuse/neglect audits, assessments, interviews, and questionnaires on 05/30/14 for any indications of abuse/neglect concerns.</p> <p>--The facility's Regional Nurse Consultant from the corporate office re-educated the facility Administrator, the DON, the ADONs, the Minimum Data Set (MDS) Coordinator, the Staff Development Coordinator (SDC), the Director of Dining Services, the Business Office Manager, the Social Services Director, the Activities Director, the Chaplain, Marketing/Admissions, Medical Records, Human Resources, and Wound Care staff on 05/29/14 on the facility's abuse policy and procedure. The education included but was not limited to thorough investigations, reporting immediately, and the Quality Assurance Performance Improvement (QAPI) process,</p>	F 226	The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.		

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F 226	<p>Continued From page 43</p> <p>including reporting of concerns to the Administrator and floor staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and questions and included examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident-to-resident altercations to include verbal or physical, and taking belongings or exploitation. Department administrative managers were not allowed to return to work until abuse education was provided, post-tests administered, and a score of 100% obtained. If the manager did not score 100% on post-test, then the manager was immediately re-educated and re-tested. This process continued until all managers obtained a 100% score on the post-test. All post-tests were reviewed for compliance by the Chief Nursing Executive (CNE).</p> <p>--After the facility Administrator, DON, ADONs, Minimum Data Set (MDS) Coordinator, Staff Development Coordinator (SDC), Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions staff, Medical Records staff or Director, Human Relations (HR) staff, or Wound Care staff were re-educated on the abuse policy, the Administrative staff was assigned to re-educate the staff on the abuse policy and procedure which included but was not limited to reporting, protection, and investigation requirements, which started on 05/29/14. The facility did not allow any employee to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and</p>	F 226			

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F 226	<p>Continued From page 44</p> <p>the post-test re-administered. This process continued until all employees obtained a 100% score on the post-test. Education regarding the abuse policy and procedure, including identification/reporting and the Quality Assurance Performance Improvement process was added in the orientation process for all newly hired staff members. No newly hired employee would be allowed to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and re-tested. This process continued until employees obtained a 100% score on the post-test.</p> <p>--Staff questionnaires regarding abuse, including the question, "What would you do if a resident told you that you were mean to them?" were administered by the Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff to five staff members on each shift and different staff members until immediacy was removed. After removal of immediacy, ten staff questionnaires were administered to staff daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating, and reporting of abuse/neglect. The questionnaire also included questions related to the QAPI process to include reporting of concerns to the Administrator and floor staff participation in development of the QAPI plan. Results of the staff questionnaire were reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of the plan. At that time,</p>	F 226			

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F 226	<p>Continued From page 45</p> <p>based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigation of suspected abuse/neglect was investigated/completed and reporting guidelines were met.</p> <p>—HR performed an audit of all personnel files for any abuse concerns on 05/29/14. Items that were reviewed: Coaching and Counseling forms, suspension forms, and termination forms. Results of the audit were given to the Chief Nursing Executive on 05/30/14, to review for any abuse/neglect concerns that needed reporting. There were no concerns identified.</p> <p>—A nurse from the facility's regional team or corporate office had been on-site since 05/29/14 and remained in the facility daily until the jeopardy was removed. The nurses from the regional team or home office assisted with investigations, observed staff treatment of residents, performed chart audits, and provided oversight and consultation. The Chief Nurse Executive, Clinical Compliance Nurse, or Director of Clinical Programs were in daily contact with the regional nurse consultant and reviewed allegations.</p> <p>—All facility grievances filed since 04/01/14 were reviewed by the Administrator, DON, or Regional Nurse Consultant on 05/30/14 to determine if any items documented were a reportable event. The Administrator was notified of one allegation of possible abuse. The Administrator reported the allegations to the Office of Inspector General on 05/30/14. The Administrator, Social Services Director, or the Director of Nursing reviewed the</p>	F 226			

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F 226	<p>Continued From page 46</p> <p>grievances and incident/accident reports daily, until immediacy was lifted, which was initiated on 05/29/14, to determine if there were reportable allegations that had not been identified. The Social Services Director or the Director of Nursing reported to the Administrator any identified allegations of abuse, neglect, or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect, or misappropriation to the Office of Inspector General, Adult Protective Services, and the Ombudsman.</p> <p>--An emergency resident council meeting was held on 05/30/14; the Administrator and SDC attended the meeting to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. The Social Services Director attempted to contact the POAs of all residents with BIMS scores less than 8 to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution on 05/30/14.</p> <p>--The Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, and Wound Care Nurse (one per shift) were to be on-site each shift to perform walking rounds in which ten residents (five with BIMS scores greater than 8 and five with BIMS scores less than 8) were visited by the Department Head and those residents that could be interviewed were interviewed regarding the staff treatment. The Department Head visited and a nurse conducted a skin check on the residents that were not able</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 226	Continued From page 47 to be interviewed. The Department Head also spoke to nursing staff and State Registered Nursing Assistants (SRNAs) regarding any noted changes in the residents' behaviors. The facility Department Head also interviewed five staff members each shift regarding the types of abuse, who the facility's Abuse Coordinator was, when to report suspected abuse, what to do if the resident reported you were mean to them, etc., which began on 05/29/14 and continued until the immediate jeopardy was lifted. Results of resident and staff questionnaires were reported to the Administrator, DON, Regional Nurse Consultant, or Vice President (VP) of Operations daily and if the Administrator was not in the facility, the Department Director conducted the questionnaires and telephoned the Administrator or VP of Operations with the results of the resident and staff questionnaires. This continued until the immediate jeopardy was lifted. -The DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff immediately notified the Administrator of any concerns regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect, or misappropriation and ensured the resident was safe. A binder (which contains a resident roster in which the interview date and shift is noted next to the resident name), which is passed on to each Department Head assigned to perform the resident and staff questionnaires each shift, to ensure that residents with BIMS scores greater than 8 were interviewed and residents with BIMS scores less than 8 were visited and skin checks completed, began on	F 226			

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F 226	<p>Continued From page 48</p> <p>05/29/14 and continued until the Jeopardy was lifted. The MDS Coordinators had the responsibility for updating the binder weekly to identify residents with BIMS scores greater than 8 and residents with BIMS scores less than 8. If abuse, mistreatment, neglect, or misappropriation was alleged during the interviews or visits or reported by a staff member, the Department Head ensured the resident was safe, reported to a Charge Nurse, the Charge Nurse removed the alleged perpetrator to a non-patient care area, and notified the Administrator, Director of Nursing, and/or Social Services Director/Abuse Coordinator. The alleged perpetrator was suspended and an investigation began immediately.</p> <p>--The Administrator, Director of Nursing, Social Services Director, or a member of the facility's regional staff reviewed all resident and staff questionnaires daily for any grievances/concerns. Investigations of grievances/concerns were initiated upon receipt, starting on 05/30/14.</p> <p>--Nursing Administration (DON, ADONs, Unit Managers, SDC, MDS staff, facility formulary nurse), or the Medical Records or Social Services Director, reviewed documentation in the Nursing Notes in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on ten different residents each day. If any of the above concerns were identified, the member of Nursing Administration first ensured the resident was safe by performing an assessment and then notified a Charge Nurse. The abuse policy was followed in which the alleged perpetrator was removed from a resident care area (if on duty) and the Administrator, DON, or Social Services Director</p>	F 226			

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F 228	<p>Continued From page 49 was notified.</p> <p>—All resident charts were reviewed from 04/01/14 by Nursing Administration (DON, ADONs, Unit Manager, Staff Development Coordinator, MDS staff, Facility Formulary Nurse, Medical Records, Marketing/Admissions, or Social Services Director) or regional/corporate nurses by 05/30/14 for any documentation regarding abuse with no new incident being identified. Ten charts were reviewed by a member of Nursing Administration or the facility's regional or home office nurse daily to ensure that no other abuse allegations had been documented but not reported. This continued until the immediate jeopardy was removed.</p> <p>—The Administrator, Director of Nursing, and Social Services Director reviewed and discussed all abuse investigations daily to ensure that the residents were protected, the alleged perpetrator was removed from the resident care area, reports to the Office of Inspector General were filed timely, and a thorough investigation was completed. The Administrator maintained an abuse investigation log that included documentation of the following: ensured protection of residents, removed perpetrator from resident care area, reports to the Office of Inspector General filed timely, and thorough investigations completed. The Administrator and one of the following, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant, reviewed the abuse investigation to ensure protection of the resident; that the perpetrator was removed from the resident care area; that reports to the Office of Inspector General were filed timely; and that a thorough investigation had been completed. This will occur</p>	F 228			

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F 228	<p>Continued From page 50 daily until removal of immediate jeopardy.</p> <p>—For new reports of alleged abuse, neglect, or misappropriation of property, after the immediate jeopardy was removed, one of the following was contacted prior to making the final five-day investigation report to OIG: Signature Care Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator, or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or Chief Nursing Executive) ensured the resident was protected, report was filed timely, the perpetrator was removed from the patient care area, and a thorough investigation was completed.</p> <p>—With any new report of alleged abuse, neglect, or misappropriation of property, one of the following was contacted within 24 hours to review the abuse investigation to ensure that a thorough investigation was completed and reporting timelines were met: Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or CNE.</p> <p>—All incident reports from January 2014 to 03/29/14 were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any concerns of suspected neglect by 05/30/14. None was identified.</p> <p>—During care plan conference for each resident, any abuse/neglect concerns were discussed and abuse/neglect education, to include reporting, was provided to the resident and/or POA with supporting documentation noted.</p>	F 228			

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F 226	<p>Continued From page 51</p> <p>—Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the CEO daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>—The DON, ADONs, or SDC observed the care delivery for any suspected abuse/neglect concerns on five residents daily until the removal of immediacy and then weekly (Monday through Friday). The results of the care delivery audits were reported to the QA Committee weekly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA Committee would determine at what frequency the audits needed to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigations of suspected abuse/neglect were investigated/completed and reporting guidelines were met.</p> <p>—A Quality Assurance meeting was held weekly for four weeks beginning 05/29/14, then monthly for recommendations and further follow-up regarding the above stated plan. At that time, based upon evaluation, the QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting was to be completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the Chief Executive</p>	F 226			

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F 226	<p>Continued From page 52</p> <p>Officer (CEO) daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interviews with Administrative Staff revealed the allegation involving Resident #32 was investigated and reported to the appropriate State agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation involving Resident #33 was investigated and reported to the appropriate state agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation that involved Resident #35 was investigated and reported to the appropriate state agency. The investigation included interviews with Resident #35, staff, and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p>	F 226			

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F 226	<p>Continued From page 53</p> <p>Review of the facility's assessments for signs and symptoms of abuse and resident interviews revealed the facility completed them on 05/29/14. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed as of 06/03/14, only six POAs had not been contacted so the facility sent the abuse/neglect questionnaire by certified mail to the POAs. A review of the abuse/neglect assessments, abuse/neglect audits, and abuse/neglect interviews revealed the Administrative staff provided validation and oversight.</p> <p>Review of Administrative staff education and testing, provided on 05/29/14, related to abuse/neglect policy, investigations, reporting, and the Quality Assessment process was reviewed and validated by the Chief Nursing Executive (CNE).</p> <p>Review of staff education and post-testing related to the abuse policy and procedure which included reporting, protection, and investigation requirements revealed the education was provided on 05/29/14, as per the AOC. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM, revealed during the staff in-service examples were given of different situations of abuse/neglect and the staff had to explain the appropriate actions. Further interview with the Regional Nurse Consultant revealed the facility had not hired any new employees.</p> <p>A review of the staff questionnaire regarding abuse was being done as reported in the AOC. Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed no issues had been identified through the staff</p>	F 226			