

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

PRINTED: 10/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2013
NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

F 000

An abbreviated/partial extended survey investigating complaints (KY20729, KY20730 and KY20731) was conducted on 09/24/13 through 10/09/13 to determine the facility's compliance with Federal requirements. KY20730 was unsubstantiated with an unrelated deficiency cited related to Quality of Care at F315 at a scope and severity of a "D". KY 20731 was substantiated with a deficiency cited related to Quality of Care at F364 at a scope and severity of a "D". KY20729 was substantiated with Immediate Jeopardy identified, on 10/02/13, and determined to exist on 08/20/13, at 42 CFR 483.13 Resident Behavior and Facility Practice at F225 and F226; and, 42 CFR 483.75 Administration at F490, at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of the Immediate Jeopardy on 10/02/13.

On 08/10/13, the facility noted Resident #1 had an injury of unknown source to his/her left hand. There was no documented evidence the facility conducted an investigation of this injury. On 08/20/13, Adult Protective Services (APS) notified the facility's Social Service Director (SSD), who is the Abuse/Neglect Coordinator, and responsible for investigating allegations of abuse, that they were investigating an allegation of abuse that a staff member injured Resident #1. It was alleged staff pulled the resident, by his/her wrist down the hall, causing an injury. There was no documented evidence the facility initiated an investigation of abuse, protected the residents from the alleged perpetrator or notified the State Survey Agency (SSA), after this notification.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Joseph B. Vance

Administrator

November 1, 2013

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 An acceptable Allegation of Compliance (AoC) was received on 10/08/13, alleging removal of the Immediate Jeopardy on 10/09/13. The State Survey Agency validated, on 10/09/13, the Immediate Jeopardy was removed on 10/09/13, as alleged. The scope and severity was lowered to a "D" at 42 CFR 483.13 Resident Behavior and Facility Practice F225 & F226; and, at 42 CFR 483.75 Administration F490 while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.	F 000			
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF October 09, 2013 F 225 The alleged perpetrator was put on administrative leave on 9/27/13 and not allowed to work with the resident #1. An investigation was started on 9/27/13 by the Social Services Director related to the allegation of abuse alleged on 8/20/13. The investigation was completed on 10/4/13. The employment of the alleged perpetrator was terminated on 10/4/13. The investigation on the injury of unknown origin identified on 8/10/13 on		11/20/2013

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F 225	Continued From page 2 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy and procedure review, it was determined the facility failed to have an effective system in place to ensure all alleged violations involving abuse to include injuries of unknown origin were immediately reported to the Administrator and appropriate State agencies; thorough investigations were conducted and actions were taken to protect the residents from further potential abuse for one (1) of eight (8) sampled residents (Resident #1). On 08/10/13, the facility identified Resident #1 had an injury of unknown source (bruising) to his/her left hand. There was no documented evidence the facility conducted an investigation of this injury. On 08/20/13, Adult Protective Services (APS) notified the facility's Social Service Director (SSD), who is the Abuse/Neglect Coordinator, and responsible for investigating allegations of abuse, that they were investigating an allegation of abuse that a staff member injured Resident #1. It was alleged staff	F 225	resident #1 was started by the Restorative Nurse on 9/27/13. It was determined that the bruise occurred on second shift on 8/9/13. It was noted on the electronic documentation on 8/9/13 that the resident was hitting, shoving and kicking at staff. No bruise was identified until 8/10/13. Audits were done by the Director of Nursing and Social Services Director on 10/3/13 with 27 interviewable resident's (those with a BIMS score of 8 or above) asking if they had been abused or mistreated. All 27 residents denied abuse. There were 38 residents who were not interviewable. All 38 residents were observed on 10/3/13 for signs and symptoms of abuse using observation of skin assessments, family interviews to detect changes or concerns. On 10/3/13 the Director of Nursing audited 104 incident reports for the past 3 months. To assess if any of the incident reports indicated any suspected abuse, mistreatment, neglect, and source of injury unknown or misappropriation of property and if any further investigation was needed. The audit included review of the incident reports, medical records and staff interviews if indicated. The Quality Assurance Nurse has reviewed 24 grievance reports on 10/3/13 to see if any of those would have been suggestive of abuse, neglect, mistreatment, or misappropriation of funds. This also		

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F 225	Continued From page 3 pulled the resident, by his/her wrist down the hall, causing an injury. There was no documented evidence the facility initiated an investigation of abuse, protected the residents from the alleged perpetrator or notified the State Survey Agency (SSA), after this notification. The facility's failure to have an effective system in place to ensure allegations of abuse and injuries of unknown origin were investigated; action was taken to prevent further potential abuse during an investigation; and allegations of abuse and injuries of unknown origin were reported to the SSA has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 10/02/13, and determined to exist on 08/20/13, at 42 CFR 483.13 Resident Behavior and Facility Practice at F225 & F226; and, 42 CFR 483.75 Administration at F490, at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of Immediate Jeopardy on 10/02/13. An acceptable Allegation of Compliance (AoC) was received on 10/08/13 alleging removal of the Immediate Jeopardy on 10/09/13. The State Survey Agency validated, on 10/09/13, the Immediate Jeopardy was removed on 10/09/13, as alleged. The Scope and Severity was lowered to a "D" at 42 CFR 483.13 Resident Behavior and Facility Practice with F225 and F226; and, 42 CFR 483.75 Administration with F490, while the facility implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors for the effectiveness of system changes. The findings include:	F 225	included review of the grievance log as well as staff interviews. The Administrative staff (Administrator, Director of Nursing, Restorative Nurse, Business office Manager, Personnel Director, Laundry Manager, Activities Director, Environmental Director, Maintenance Director, RAI Nurses, Dietary Manager, Medical Records Manager, Social Services Director and QA/In-service Coordinator) was In-serviced on 10/8/13 by Kay Stevens, RN Nurse Consultant KAHCF Committee member on the Abuse, Neglect, Mistreatment and misappropriation of funds Policy which includes the seven components of the abuse prevention protocol. The Administrative staff was also required to take a post test with 100% accuracy. All staff was In-serviced 10/2/13 thru 10/4/13 on abuse, neglect, mistreatment and misappropriation of funds Policy which included the seven components of the abuse prevention protocol with the requirement that a 20 question test be passed with 100% accuracy. Our orientation program will now include in-service by the In-service Coordinator for all new employees before they are allowed to give direct care. This includes new hires or contract labor should we employ them. They will not be allowed to work unless they have passed the abuse test with 100% accuracy.		

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F 225	Continued From page 4 Review of the facility's policy entitled, "Reporting & Investigation of Abuse, Neglect, Mistreatment, Exploitation and/or Misappropriation of Resident Property", last revised 07/21/10, revealed: If an injury is noted and the source of the injury cannot be identified, the abuse investigation is started as described below with the goal of determining what caused the injury and ruling out any instance of abuse. The facility's Injury of Unknown Etiology Investigation Form will be started by the Social Service Director (SSD) or his or her designee after he/she is notified by a staff member or family member noting the injury. It is imperative that the injury be reported to the SSD, the Director of Nursing (DON) and the Administrator immediately. In addition, the policy and procedure revealed all personnel must immediately report an incident or suspected incident of resident abuse, neglect or mistreatment including injuries of an unknown source or misappropriation of resident property. Observation of an incident of resident abuse or suspecting resident abuse must be reported to the charge nurse or supervisor and the DON/designee, SSD and Administrator should be notified immediately, with the investigation starting immediately. The resident should be removed from harm and examined and the examination recorded in the medical record. If the allegation of abuse is against a staff member, that person is to "leave the building immediately and will be denied unsupervised access to the residents", that staff is placed on administrative leave pending the outcome of the investigation. The Administrator or his/her designee is to immediately notify the State agency and the Adult Protective Services (APS) as required by state law. An immediate investigation will be made by the SSD and a copy of the findings will be	F 225	An audit on interviewable residents (those with a BIMS score of 8 or above) asking them if they have been mistreated or abused will be done by the Social Services Director once a week for 8 weeks of 100% compliance. This audit will be continued for at least every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on non-interviewable residents (those with a BIMS score of below 8) observing them for signs and symptoms of abuse using skin assessments & family interviews. This audit will be done by the Social Services Director once a week for 8 weeks of 100% compliance. This audit will be continued for at least every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on incident reports will be done by the Director of Nursing weekly for 8 weeks of 100% compliance. This audit will be continued every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on staff as to their understanding of the seven components of the abuse prevention protocol by the QA/In-service Coordinator will be done once a week for 8 weeks of 100% compliance. This audit will be continued for at least 6 months. An audit reviewing grievances by the QA/In-service Coordinator will be done once a week for 8 weeks of 100% compliance.		

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F 225	<p>Continued From page 5</p> <p>provided to the Administrator or his/her designee per "Allegation of Abuse Investigation Form-Appendix E". The State agency is to be notified within five (5) working days of the occurrence. The Administrator or his/her designee will inform the resident and his/her legal representative of the results of the investigation and corrective action taken.</p> <p>Record review revealed the facility admitted Resident #1 on 05/13/13 with diagnoses which included Dementia, Symbolic Dysfunction, Muscular Wasting and Disuse Atrophy. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 08/16/13, revealed the facility assessed Resident #1's cognition as severely impaired and he/she required assistance with all activities of daily living.</p> <p>Review of a Nursing Note, dated 08/10/13, and a skin assessment, dated 08/11/13, revealed the facility identified Resident #1 had a bruise covering the top of his/her left hand. Further record review revealed there was no evidence of the cause of the bruise or of a facility investigation to determine the cause of the bruise.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 who obtained an order for an x-ray of Resident #1's wrist, on 10/01/13 at 11:53 AM, revealed she did not fill out a form related to the bruise covering Resident #1's left hand. LPN #3 stated she did not know what caused the bruise and she did not check to see if a report had been made.</p> <p>Interview with the SSD who is also the Abuse/Neglect Coordinator, on 09/30/13 at 12:50 PM, revealed she was aware of the bruise on Resident #1's hand because she had read about</p>	F 225	This audit will be continued for at least 6 months. These audits will be conducted as part of the Facility's Quality Assurance Program.		

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F 225	Continued From page 6 the bruise in the Nursing Notes. The SSD stated the Injury of Unknown Etiology Investigation form should have been completed and an investigation conducted to try to determine the cause of the injury and rule out abuse. The SSD revealed the form was not completed and investigation of the injury was not initiated. Further interview with the SSD, on 09/25/13 at 6:00 PM, on 09/27/13 at 11 AM and 2:15 PM, on 09/30/13 at 12:50 PM, and on 10/01/13 at 10:25 AM, revealed APS had made her aware on 08/20/13 that there was an allegation that a CNA had dragged Resident #1 down the hall by the resident's wrist. The SSD stated when an allegation is received against a staff member it was the facility's policy to have the staff member go to the conference room to take their statement and then send him/her home until the investigation was completed. The Administrator and DON should be notified and an investigation should be initiated immediately. The SSD stated the SSA and APS should be notified within twenty-four (24) hours and the final investigation results should have been reported within five (5) days to the SSA. The SSD revealed an initial allegation form and allegation of Abuse Investigation form should be completed for the abuse allegation. The SSD revealed these forms were not completed and staff did not conduct a head to toe skin assessment of Resident #1. The SSD stated she should have notified the DON, Administrator and the SSA immediately, conducted a thorough investigation and determined if the allegation was or was not substantiated. The SSD stated APS unsubstantiated the allegation so she unsubstantiated it because "they are the experts".	F 225			

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F 225	<p>Continued From page 7</p> <p>Review of CNA #1's Employee Daily Activity Report revealed she had worked twenty-six (26) days from 08/20/13 through 09/26/13. Interview with CNA #1, on 09/26/13 at 6:45 PM, revealed she was aware an allegation of abuse was made against her but she had not been placed on administrative leave.</p> <p>Interview with the DON, on 09/27/13 at 11:45 AM and 1:45 PM, and on 09/30/13 at 2:39 PM revealed the Administrator, SSD, and she should be notified immediately if an allegation is made. The DON stated the resident should be removed from any suspected harm, the staff member should be suspended and walked out of the building by staff, and an investigation should be initiated and the SSA should be notified immediately. The DON stated she was made aware of the allegation on 08/20/13 by the SSD, who informed her an allegation had been made that a staff member had roughly handled Resident #1. The DON further revealed a skin assessment had not been done on Resident #1 following the allegation, and the SSA was not made aware of the allegation. The DON stated it was the Administrator's, SSD and her responsibility to ensure an investigation was completed.</p> <p>Interview with the Administrator, on 10/01/13 at 9:25 AM; and, on 10/02/13 at 3:22 PM revealed he was not made aware of the allegation of abuse that involved Resident #1 until 09/25/13. He stated CNA #1 continued to work and was not placed on administrative leave and an investigation was not initiated until 09/27/13.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>On 09/27/13, the alleged perpetrator was put on administrative leave and not allowed to work with residents and an investigation was initiated by the Social Services Director (SSD) related to the allegation of abuse involving Resident #1 and CNA #1. In addition, an investigation was initiated related to Resident #1's injury of unknown injury by a Restorative Nurse. The investigations involved staff interviews, record reviews, and review of electronic documentation. Subsequently, the alleged perpetrator was terminated on 10/04/13 for failure to get along with other staff.</p> <p>The SSD was trained on investigations of alleged abuse, mistreatment, neglect and misappropriation of funds by the Nurse Consultant on 10/08/13.</p> <p>The Administrative Staff (Administrator, DON, Restorative Nurse, Business Office Manager, Human Resources Manager, Laundry Manager, Activities Director, Environmental Director, Maintenance Director, RAI Nurses, Dietary Manager, Medical Record Manager, Social Service Director, and QA Inservice Coordinator) was inserviced by the RN Consultant on the Abuse, Neglect, Mistreatment and Misappropriation of Funds policy which include the seven components of the Abuse Prevention Protocol on 10/08/13. The staff was required to take a post test and receive 100% accuracy.</p> <p>All staff was inserviced on the Abuse Neglect, Mistreatment and Misappropriation of Funds policy including the seven (7) components of the Abuse Prevention Protocol on 10/02-10/04/13 by the QA/Inservice Coordinator/Nurse Aide</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>Instructor. The staff was required to take a post test and pass with 100% accuracy. Staff involved in the policy inservice training included: nurses, certified medical assistants (CMA), CNAs, ward clerks, business office, nurse aides, activity workers, maintenance department, social services, receptionist, environmental services department, laundry department, maintenance department, dietary department, and therapy.</p> <p>The orientation program will include an inservice on the Abuse Policy and the seven (7) criteria by the Inservice Director for all new employees before they were allowed to give direct care. This includes new hires, contract labor and agency staff if used. The new employees will be given a post test and must pass with 100% accuracy.</p> <p>On 10/03/13, the DON and SSD conducted audits with twenty-seven (27) interviewable residents (those with BIMs score of eight (8) and above) asking if they had been abused or mistreated with all residents denying abuse with no concerns noted. Non-interviewable residents were observed for signs and symptoms of abuse using observation, of skin assessments, and family interviews to detect changes or concerns, with no concerns noted.</p> <p>A Quality Assurance (QA) audit was conducted on interviewable residents by the SSD asking if they have been mistreated or abused once a week for eight (8) weeks of 100% compliance and continued for at least six (6) months, with the QA audit being brought to and reviewed at quarterly and interim QA meetings by the Social Service Director. The audit will also include the thirty-eight (38) non-interviewable residents. They will be observed for signs and symptoms of</p>	F 225			

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F 225	<p>Continued From page 10</p> <p>abuse during weekly skin assessments and family interviews. This audit will be done once a week for eight weeks of 100 % compliance. This audit will be continued for at least three (3) months. If any issues are identified they will be immediately investigated. The QA audit will be brought to and reviewed at quarterly and interim QA meetings by the Social Service Director.</p> <p>On 10/03/13, the DON audited one-hundred four (104) incident reports for the past three (3) months to assess for suspected abuse, mistreatment, neglect and source of injury unknown origin. The audit consisted of review of incident reports, medical records and staff/resident interviews if needed. If issues were identified they were investigated. This audit will continue at least monthly for three (3) months with 100% compliance with random audits continued quarterly.</p> <p>The QA nurse reviewed twenty four (24) grievances on 10/03/13 which consisted of review of grievance forms, grievance log and staff interviews to see if any would have been suggestive of abuse with no abuse noted. This audit will be done by the QA nurse once a week for eight (8) weeks of 100% compliance and be continued for at least six (6) months, with the audit being brought to and reviewed at quarterly and interim QA meetings by the QA nurse.</p> <p>The QA nurse will conduct an audit once a week for eight (8) weeks to establish the staff understands the seven (7) components of the abuse prevention protocol. The audit consist of interviewing staff on screening, training, prevention, identification, investigation protection, reporting and responding; with the audit being</p>	F 225			

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F 225	<p>Continued From page 11</p> <p>done once a week for eight (8) weeks of 100% compliance, for at least six (6) months.</p> <p>The State Survey Agency validated the corrective action by the facility as follows:</p> <p>Review on 10/08/13 of the activity audits of all departments revealed CNA #1 was not working in the facility from 09/27/13 through 10/05/13. Interview with the DON, on 10/09/13 at 9:00 AM, revealed CNA #1 had not worked at the facility since being put on administrative leave on 09/27/13.</p> <p>Review of the facility's inservices, dated 10/02/13 through 10/04/13 and 10/08/13, revealed all staff which included the Administrative staff was inserviced on the seven (7) components of the abuse prevention policy. Review of the abuse tests revealed staff scored 100%. The Administrative staff also received an additional inservice by a Registered Nurse (RN) Consultant on the seven (7) components of the abuse prevention policy. Review of the abuse test results revealed staff scored of 100%.</p> <p>Interviews on 10/09/13 from 11:00 PM to 5:55 PM with fourteen (14) CNAs, six (6) nurses, three (3) Certified Medicine Aides (CMA), two (2) Therapy Aides, three (3) Dietary Aides, a Receptionist, a Ward Clerk/Medical Records, two (2) Minimum Data Set/Resident Assessment Instrument nurses, one (1) Maintenance, two (2) laundry aides, and six (6) Housekeeping Aides revealed they had received an inservice on the seven (7) components of abuse and had made 100 % on required test given by the Quality Assurance (QA)/Inservice Coordinator/Nurse Aide Instructor nurse from 10/02/13 through 10/04/13.</p>	F 225			

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F 225	Continued From page 12 Interviews on 10/09/13 at 1:00 PM through 5:00 PM with Administrative staff, to include the Administrator, DON, Restorative Nurse, Dietary Supervisor, Activity Director, SSD, Maintenance Director, Laundry Supervisor, Housekeeping Supervisor, and Business Office Manager revealed they had been inserviced on the seven (7) components of abuse and had made 100% on the required test. In addition the Administrative staff revealed they had received an additional inservice by an outside Nurse Consultant on 10/08/13 on the seven (7) components of abuse and had made 100% on the required test. Interview with the QA/Inservice Coordinator/Nurse Aide Instructor, on 10/09/13 at 2:00 PM revealed she will inservice new hires on the seven (7) components of abuse and the new hires will be required to take the test and make 100% before they will be allowed to work on the floor. Interview on 10/09/13 at 11:00 AM with the DON and QA/Inservice Coordinator/Nurse Aide Instructor revealed all staff had been inserviced on the seven (7) components of abuse and had made 100% on the required test. The DON and QA/Inservice Coordinator/Nurse Aide Instructor further revealed Administrative staff had received an additional inservice by an outside Nurse Consultant on 10/08/13 on the seven (7) components of abuse and had made 100% on the required test afterward. Review of QA Audits dated 10/09/13 revealed interviewable residents were interviewed by the SSD and she asked them if they had been mistreated or abused. The QA audit also included the thirty-eight (38) non-Interviewable	F 225			

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F 225	<p>Continued From page 13</p> <p>residents observed for signs and symptoms of abuse during weekly skin assessments and family interviews. Interview on 10/08/13 at 10:00 AM and on 10/09/13 at 12:20 PM with the SSD and DON revealed they completed the resident interviews with interviewable residents and family interview with non-interviewable residents' family. The SSD and DON stated they observed the residents to determine if there were any signs or symptoms of abuse.</p> <p>A review of the Incident Log Audit, on 10/09/13, revealed the audit had been completed. Interview on 10/09/13 at 12:45 PM with the DON revealed she had audited the incident log and would now be using the CQI form designated for review of event reports to adequately identify, investigate, screen, and follow up on potential abuse for future events and if issues were identified they would be investigated. This audit will continue at least monthly for three (3) months with 100% compliance with random audits continued quarterly with summarization being taken to QA meetings.</p> <p>Review of the CQI form for grievances, the Grievance Log and interview with the QA/Inservice Coordinator/Nurse Aide Instructor, on 10/09/13 at 3:00 PM revealed she utilized the CQI review to ensure grievances were resolved promptly and to ensure screening and follow up on suspected abuse. The audit will be completed by the QA nurse once a week for eight (8) weeks of 100% compliance and be continued for at least six (6) months, with the audit being brought to and reviewed at quarterly and interim QA meetings by the QA nurse. In addition, the CQI review form was completed to ensure staff had an understanding and are compliant with the</p>	F 225			

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F 225	Continued From page 14 abuse policy related to screening, training, prevention, identifying, investigating, protection and reporting will be utilized at the facility. Record review for Residents #9, #10 and #11 revealed a bruise of unknown origin was identified on Resident #10 with the facility initiating an investigation and notification sent to the State agency. Record reviews for Resident #9 and Resident #11 revealed no concerns. Review of the audits and monitoring tools initiated for tracking the effectiveness of the implemented policy, revealed no concerns. Interviews with the DON, QA/inservice Coordinator/Nurse Aide instructor, and SSD on 10/09/13 revealed they would ensure the audits and monitoring would continue as stated in the Allegation of Compliance.	F 225			
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy and procedure review it was determined the facility failed to implement it's policy and procedure related to abuse and injury of unknown origin for one (1) of eight (8) sampled residents (Resident #1). On 08/10/13, the facility noted	F 226	F 226 The alleged perpetrator was put on administrative leave on 9/27/13 and not allowed to work with the resident #1. An investigation was started on 9/27/13 by the Social Services Director related to the allegation of abuse alleged on 8/20/13. The investigation was completed on 10/4/13. The employment of the alleged perpetrator was terminated on 10/4/13. The investigation on the injury of unknown origin identified on 8/10/13 on resident #1 was started by the Restorative Nurse on 9/27/13. It was determined that the bruise occurred on second shift on	11/20/2013	

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F 226	<p>Continued From page 15</p> <p>Resident #1 had an injury of unknown source to his/her left hand. There was no documented evidence the facility followed its policy and procedure related to conducting an investigation of this injury. On 08/20/13, Adult Protective Services (APS) notified the facility's Social Service Director (SSD), who is the Abuse/Neglect Coordinator, and responsible for investigating allegations of abuse, that they were investigating an allegation of abuse that a staff member injured Resident #1. It was alleged staff pulled the resident, by his/her wrist down the hall, causing an injury. There was no documented evidence the facility followed its policy and procedure related to initiating an investigation of abuse, protecting the residents from the alleged perpetrator or notifying the State Survey Agency (SSA), after this notification.</p> <p>The facility's failure to follow its policy and procedure to ensure allegations of abuse and injuries of unknown origin were investigated, action was taken to prevent further potential abuse during an investigation, and allegations of abuse and injuries of unknown origin were reported to the SSA has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 10/02/13, and determined to exist on 08/20/13, at 42 CFR 483.13 Resident Behavior and Facility Practice at F225 & F226, and 42 CFR 483.75 Administration at F490, at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of Immediate Jeopardy on 10/02/13. An acceptable Allegation of Compliance (AoC) was received on 10/08/13 alleging removal of the Immediate Jeopardy on 10/09/13. The State Survey Agency validated, on</p>	F 226	<p>8/9/13. It was noted on the electronic documentation on 8/9/13 that the resident was hitting, shoving and kicking at staff. No bruise was identified until 8/10/13.</p> <p>Audits were done by the Director of Nursing and Social Services Director on 10/3/13 with 27 interviewable resident's (those with a BIMS score of 8 or above) asking if they had been abused or mistreated. All 27 residents denied abuse. There were 38 residents who were not interviewable. All 38 residents were observed on 10/3/13 for signs and symptoms of abuse using observation of skin assessments, family interviews to detect changes or concerns. On 10/3/13 the Director of Nursing audited 104 incident reports for the past 3 months. To assess if any of the incident reports indicated any suspected abuse, mistreatment, neglect, and source of injury unknown or misappropriation of property and if any further investigation was needed. The audit included review of the incident reports, medical records and staff interviews if indicated. The Quality Assurance Nurse has reviewed 24 grievances reports on 10/3/13 to see if any of those would have been suggestive of abuse, neglect, mistreatment, or misappropriation of funds. This also included review of the grievance log as well as staff interviews.</p>		

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F 226	<p>Continued From page 16</p> <p>10/09/13, the Immediate Jeopardy was removed on 10/09/13, as alleged. The scope and severity was lowered to a "D" at 42 CFR 483.13 Resident Behavior and Facility Practice with F225 & F226, and 42 CFR 483.75 Administration with F490, while the facility implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors for the effectiveness of system changes.</p> <p>The findings include:</p> <p>Review of facility's policy entitled, Reporting & Investigation of Abuse, Neglect, Mistreatment, Exploitation and/or Misappropriation of Resident Property", last revised 07/21/10, revealed: If an injury is noted and the source of the injury cannot be identified, the abuse investigation is started as described below with the goal of determining what caused the injury and ruling out any instance of abuse. The facility's Injury of Unknown Etiology Investigation Form will be started by the Social Service Director (SSD) or his or her designee after he/she is notified by a staff member or family member noting the injury. It is imperative that the injury be reported to the SSD, the Director of Nursing (DON) and the Administrator immediately. In addition, the policy and procedure revealed all personnel must immediately report an incident or suspected incident of resident abuse, neglect or mistreatment including injuries of an unknown source or misappropriation of resident property. Observation of an incident or resident abuse or suspecting resident abuse must be reported to the charge nurse or supervisor and the DON/designee, SSD and Administrator should be notified immediately, with the investigation starting immediately. The resident should be</p>	F 226	<p>The Administrative staff (Administrator, Director of Nursing, Restorative Nurse, Business office Manager, Personnel Director, Laundry Manager, Activities Director, Environmental Director, Maintenance Director, RAI Nurses, Dietary Manager, Medical Records Manager, Social Services Director and QA/In-service Coordinator) was In-serviced on 10/8/13 by Kay Stevens, RN Nurse Consultant KAHCF Committee member on the Abuse, Neglect, Mistreatment and misappropriation of funds Policy which includes the seven components of the abuse prevention protocol. The Administrative staff was also required to take a post test with 100% accuracy. All staff was In-serviced 10/2/13 thru 10/4/13 on abuse, neglect, mistreatment and misappropriation of funds Policy which included the seven components of the abuse prevention protocol with the requirement that a 20 question test be passed with 100% accuracy. Our orientation program will now include in-service by the In-service Coordinator for all new employees before they are allowed to give direct care. This includes new hires or contract labor should we employ them. They will not be allowed to work unless they have passed the abuse test with 100% accuracy.</p> <p>An audit on interviewable residents (those with a BIMS score of 8 or above)</p>		

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F 226	Continued From page 17 removed from harm and examined and the examination recorded in the medical record. If the allegation of abuse is against a staff member, that person is to "leave the building immediately and will be denied unsupervised access to the residents", that staff is placed on administrative leave pending the outcome of the investigation. The Administrator or his/her designee is to immediately notify the State agency and the Adult Protective Services (APS) as required by state law. An immediate investigation will be made by the SSD and a copy of the findings will be provided to the Administrator or his/her designee per "Allegation of Abuse Investigation Form-Appendix E". The State agency is to be notified within five (5) working days of the occurrence. The Administrator or his/her designee will inform the resident and his/her legal representative of the results of the investigation and corrective action taken. Record review revealed the facility admitted Resident #1 on 05/13/13 with diagnoses which included Dementia, Symbolic Dysfunction, Muscular Wasting and Disuse Atrophy. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 08/16/13, revealed the facility assessed Resident #1's cognition as severely impaired and he/she required assistance with all activities of daily living. Review of a Nursing Note, dated 08/10/13, and a skin assessment, dated 08/11/13, revealed the facility identified Resident #1 had a bruise covering the top of his/her left hand. Further record review revealed there was no evidence of what caused the bruise or if the facility conducted an investigation to determine the cause of the bruise.	F 226	asking them if they have been mistreated or abused will be done by the Social Services Director once a week for 8 weeks of 100% compliance. This audit will be continued for at least every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on non-interviewable residents (those with a BIMS score of below 8) observing them for signs and symptoms of abuse using skin assessments & family interviews. This audit will be done by the Social Services Director once a week for 8 weeks of 100% compliance. This audit will be continued for at least every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on incident reports will be done by the Director of Nursing weekly for 8 weeks of 100% compliance. This audit will be continued every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on staff as to their understanding of the seven components of the abuse prevention protocol by the QA/In-service Coordinator will be done once a week for 8 weeks of 100% compliance. This audit will be continued for at least 6 months. An audit reviewing grievances by the QA/In-service Coordinator will be done once a week for 8 weeks of 100% compliance. This audit will be continued for at least 6 months. These audits will be conducted as		

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F 226	Continued From page 18 Interview with Licensed Practical Nurse (LPN) #3, on 10/01/13 at 11:53 AM, revealed she did not complete a form related to the bruise covering Resident #1's left hand. LPN #3 stated she did not know what caused the bruise and did not check to see if a report had been made. Interview with the SSD, who is also the Abuse/Neglect Coordinator, on 09/30/13 at 12:50 PM, revealed she was aware of the bruise on Resident #1's hand because she had read about the bruise in the Nursing Notes. The SSD stated the facility's policy and procedure for abuse was staff should complete the Injury of Unknown Etiology Investigation form, an investigation should have been conducted to try to determine the cause of the injury and rule out abuse and the Administrator should have been notified. The SSD revealed the facility's policy and procedure was not followed. Further interview with the SSD, on 09/25/13 at 6:00 PM, on 09/27/13 at 11 AM and 2:15 PM, on 09/30/13 at 12:50 PM, and on 10/01/13 at 10:25 AM, revealed APS had made her aware on 08/20/13 that there was an allegation that a CNA had dragged Resident #1 down the hall by the resident's wrist. The SSD stated the facility's policy and procedure for an allegation of abuse was if an allegation is received against a staff member it was the facility's policy to have the staff member go to the conference room to take their statement and then send him/her home until the investigation was completed. The Administrator and DON should be notified and an investigation should be initiated immediately. The SSD stated the SSA and APS should be notified within twenty-four hours and the final investigation	F 226	part of the Facility's Quality Assurance Program,		

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F 226	Continued From page 19 results should have been reported within five (5) days to the SSA. The SSD revealed an initial allegation form and allegation of Abuse Investigation form should be completed for the abuse allegation. The SSD revealed the facility's policy and procedure was not followed because staff failed to complete the forms. The SSD stated according to the facility's policy she should have notified the DON, Administrator and the SSA immediately, conducted a thorough investigation and determined if the allegation was substantiated or not. The SSD stated APS unsubstantiated the allegation so she unsubstantiated it because "they are the experts". Review of CNA #1's Employee Daily Activity Report revealed she had worked twenty-six (26) days from 08/20/13 through 09/26/13. Interview with CNA #1, on 09/26/13 at 6:45 PM, revealed she was aware an allegation of abuse was made against her but she had not been placed on administrative leave. Interview with the DON, on 09/27/13 at 11:45 AM and 1:45 PM, and on 09/30/13 at 2:39 PM revealed it was the facility's policy that the Administrator, SSD, and she be notified immediately if an allegation is made. The DON stated the resident should be removed from any suspected harm, the staff member should be suspended and walked out of the building by staff, an investigation should be initiated and the SSA should be notified immediately. The DON stated she was made aware of the allegation on 08/20/13 by the SSD who informed her an allegation had been made that a staff member had roughly handled Resident #1. The DON revealed the facility's policy and procedure was	F 226			

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F 226	<p>Continued From page 20</p> <p>not followed related to notification of the SSA and completing a thorough investigation. The DON stated it was the responsibility of her, the Administrator and SSD to ensure an investigation was completed.</p> <p>Interview with the Administrator, on 10/01/13 at 9:25 AM and on 10/02/13 at 3:22 PM revealed staff did not follow the facility's Abuse policy as he was not made aware of the allegation of abuse involving Resident #1 until 09/25/13. The Administrator stated the facility's policy was not followed when CNA #1 was not placed on administrative leave and an investigation was not initiated until 09/27/13.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 09/27/13, the alleged perpetrator was put on administrative leave and not allowed to work with residents and an investigation was initiated by the Social Services Director (SSD) related to the allegation of abuse involving Resident #1 and CNA #1. In addition, an investigation was initiated related to Resident #1's injury of unknown injury by a Restorative Nurse. The investigations involved staff interviews, record reviews, and review of electronic documentation. Subsequently, the alleged perpetrator was terminated on 10/04/13 for failure to get along with other staff.</p> <p>The SSD was trained on investigations of alleged abuse, mistreatment, neglect and misappropriation of funds by the Nurse Consultant on 10/08/13.</p> <p>The Administrative Staff (Administrator, DON,</p>	F 226			

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F 226	<p>Continued From page 21</p> <p>Restorative Nurse, Business Office Manager, Human Resources Manager, Laundry Manager, Activities Director, Environmental Director, Maintenance Director, RAI Nurses, Dietary Manager, Medical Record Manager, Social Service Director, and QA Inservice Coordinator) was inserviced by the RN Consultant on the Abuse, Neglect, Mistreatment and Misappropriation of Funds policy which include the seven components of the Abuse Prevention Protocol on 10/08/13. The staff was required to take a post test and receive 100% accuracy.</p> <p>All staff was inserviced on the Abuse Neglect, Mistreatment and Misappropriation of Funds policy including the seven (7) components of the Abuse Prevention Protocol on 10/02-10/04/13 by the QA/Inservice Coordinator/Nurse Aide Instructor. The staff was required to take a post test and pass with 100% accuracy. Staff involved in the policy inservice training included: nurses, certified medical assistants (CMA), CNAs, ward clerks, business office, nurse aides, activity workers, maintenance department, social services, receptionist, environmental services department, laundry department, maintenance department, dietary department, and therapy.</p> <p>The orientation program will include an inservice on the Abuse Policy and the seven (7) criteria by the Inservice Director for all new employees before they were allowed to give direct care. This includes new hires, contract labor and agency staff if used. The new employees will be given a post test and must pass with 100% accuracy.</p> <p>On 10/03/13, the DON and SSD conducted audits with twenty-seven (27) interviewable residents (those with BIMs score of eight (8) and above)</p>	F 226			

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F 226	Continued From page 22 asking if they had been abused or mistreated with all residents denying abuse with no concerns noted. Non-interviewable residents were observed for signs and symptoms of abuse using observation of skin assessments, and family interviews to detect changes or concerns, with no concerns noted. A Quality Assurance (QA) audit was conducted on interviewable residents by the SSD asking if they have been mistreated or abused once a week for eight (8) weeks of 100% compliance and continued for at least six (6) months, with the QA audit being brought to and reviewed at quarterly and interim QA meetings by the Social Service Director. The audit will also include the thirty-eight (38) non-interviewable residents. They will be observed for signs and symptoms of abuse during weekly skin assessments and family interviews. This audit will be done once a week for eight weeks of 100 % compliance. This audit will be continued for at least three (3) months. If any issues are identified they will be immediately investigated. The QA audit will be brought to and reviewed at quarterly and interim QA meetings by the Social Service Director. On 10/03/13, the DON audited one-hundred four (104) incident reports for the past three (3) months to assess for suspected abuse, mistreatment, neglect and source of injury unknown origin. The audit consisted of review of incident reports, medical records and staff/resident interviews if needed. If issues were identified they were investigated. This audit will continue at least monthly for three (3) months with 100% compliance with random audits continued quarterly.	F 226			

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F 226	<p>Continued From page 23</p> <p>The QA nurse reviewed twenty four (24) grievances pn 10/03/13 which consisted of review of grievance forms, grievance log and staff interviews to see if any would have been suggestive of abuse with no abuse noted. This audit will be done by the QA nurse once a week for eight (8) weeks of 100% compliance and be continued for at least six (6) months, with the audit being brought to and reviewed at quarterly and interim QA meetings by the QA nurse.</p> <p>The QA nurse will conduct an audit once a week for eight (8) weeks to establish the staff understands the seven (7) components of the abuse prevention protocol. The audit consist of interviewing staff on screening, training, prevention, identification, investigation protection, reporting and responding; with the audit being done once a week for eight (8) weeks of 100% compliance for at least six (6) months.</p> <p>The State Survey Agency validated the corrective action by the facility as follows:</p> <p>Review on 10/08/13 of the activity audits of all departments revealed CNA #1 was not working in the facility from 09/27/13 through 10/05/13. Interview with the DON, on 10/09/13 at 9:00 AM, revealed CNA #1 had not worked at the facility since being put on administrative leave on 09/27/13.</p> <p>Review of the facility's inservices, dated 10/02/13 through 10/04/13 and 10/08/13, revealed all staff which included the Administrative staff was inserviced on the seven (7) components of the abuse prevention policy and an abuse test was given afterward with test scores of 100%. The Administrative staff also received an additional</p>	F 226			

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F 226	<p>Continued From page 24</p> <p>inservice by an Registered Nurse (RN) Consultant on the seven (7) components of the abuse prevention policy and an abuse test was given afterward with test scores of 100%.</p> <p>Interviews on 10/09/13 from 11:00 PM to 5:55 PM with fourteen (14) CNAs, six (6) nurses, three (3) Certified Medicine Aids (CMA), two (2) Therapy Aides, three (3) Dietary Aides, a Receptionist, a Ward Clerk/Medical Records, two (2) Minimum Data Set/Resident Assessment Instrument nurses, one (1) Maintenance, two (2) laundry aides, and six (6) Housekeeping Aides revealed they had received an inservice on the seven (7) components of abuse and had made 100 % on required test given by the Quality Assurance (QA)/Inservice Coordinator/Nurse Aide Instructor nurse from 10/02/13 through 10/04/13.</p> <p>Interviews on 10/09/13 at 1:00 PM through 5:00 PM with Administrative staff, to include the Administrator, DON, Restorative Nurse, Dietary Supervisor, Activity Director, SSD, Maintenance Director, Laundry Supervisor, Housekeeping Supervisor, and Business Office Manager revealed they had been inserviced on the seven (7) components of abuse and had made 100% on the required test. In addition the Administrative staff revealed they had received an additional inservice by an outside Nurse Consultant on 10/08/13 on the seven (7) components of abuse and had made 100% on the required test.</p> <p>Interview with the QA/Inservice Coordinator/Nurse Aide Instructor, on 10/09/13 at 2:00 PM revealed she will inservice new hires on the seven (7) components of abuse and the new hires will be required to take the test and make 100% before they will be allowed to work on the floor.</p>	F 226		

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F 226	Continued From page 25 Interview on 10/09/13 at 11:00 AM with the DON and QA/Inservice Coordinator/Nurse Aide Instructor revealed all staff had been inserviced on the seven (7) components of abuse and had made 100% on the required test. The DON and QA/Inservice Coordinator/Nurse Aide Instructor further revealed Administrative staff had received an additional inservice by an outside Nurse Consultant on 10/08/13 on the seven (7) components of abuse and had made 100% on the required test afterward. Review of QA Audits dated 10/09/13 revealed interviewable residents were interviewed by the SSD and she asked them if they had been mistreated or abused. The QA audit also included the thirty-eight (38) non-interviewable residents observed for signs and symptoms of abuse during weekly skin assessments and family interviews. Interview on 10/08/13 at 10:00 AM and on 10/09/13 at 12:20 PM with the SSD and DON revealed they completed the resident interviews with interviewable residents and family interview with non-interviewable residents' family. The SSD and DON stated they observed the residents to determine if there were any signs or symptoms of abuse. A review of the Incident Log Audit, on 10/09/13, revealed the audit had been completed. Interview on 10/09/13 at 12:45 PM with the DON revealed she had audited the incident log and would now be using the CQI form designated for review of event reports to adequately identify, investigate, screen, and follow up on potential abuse for future events and if issues were identified they would be investigated. This audit will continue at least monthly for three (3) months	F 226			

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F 226	<p>Continued From page 26</p> <p>with 100% compliance with random audits continued quarterly with summarization being taken to QA meetings.</p> <p>Review of the CQI form for grievances, the Grievance Log and interview with the QA/Inservice Coordinator/Nurse Aide Instructor, on 10/09/13 at 3:00 PM revealed she utilized the CQI review to ensure grievances were resolved promptly and to ensure screening and follow up on suspected abuse. The audit will be completed by the QA nurse once a week for eight (8) weeks of 100% compliance and be continued for at least six (6) months, with the audit being brought to and reviewed at quarterly and interim QA meetings by the QA nurse. In addition, the CQI review form was completed to ensure staff had an understanding and are compliant with the abuse policy related to screening, training, prevention, identifying, investigating, protection and reporting will be utilized at the facility.</p> <p>Record review for Residents #9, #10 and #11 revealed a bruise of unknown origin was identified on Resident #10 with the facility initiating an investigation and notification sent to the State agency. Record reviews for Resident #9 and Resident #11 revealed no concerns.</p> <p>Review of the audits and monitoring tools initiated for tracking the effectiveness of the implemented policy, revealed no concerns.</p> <p>Interviews with the DON, QA/Inservice Coordinator/Nurse Aide Instructor, and SSD on 10/09/13 revealed they would ensure the audits and monitoring would continue as stated in the Allegation of Compliance.</p>	F 226			

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F 315	Continued From page 27	F 315	F 315	11/20/2013	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure staff provided appropriate catheter care and perineal care to prevent urinary tract infections for one (1) of eight (8) sampled residents (Resident #3). The staff failed to wash hands/change gloves in between touching items in the environment and providing incontinent care for Resident #3. The findings include: Review of the facility's policy entitled, "Grayson Manor Standard Precautions", not dated, revealed "Standard Precautions will be used in the care of all residents regardless of their diagnosis or presumed infection status. Standard Precautions apply to blood, body fluid, secretions, excretions regardless of whether or not they contain visible blood, non-intact skin, and mucous membranes". Under the heading of Policy Interpretation and Implementation, the policy	F 315	Nurse Aide #8, and #14, was counseled by the Infection Control Nurse on October 10 th 2013, regarding proper hand-washing, gloving and catheter care. All Nursing staff including nurse aide #8 and #14 was in-serviced on October 16 th 2013 on Infection control related to hand-washing, gloving and catheter care. The Wound Care/Infection Control Nurse has observed perineal/catheter care for all incontinent residents' and residents' with a catheter to ensure proper Infection Control techniques related to perineal/catheter care were performed. The Wound Care/Infection Control Nurse has checked off all Certified Nurse Aides after the nurse aide performed a return demonstration on infection control related to perineal/catheter care, gloving and hand-washing before and after perineal/catheter care. All Certified Nurse Aides must perform a return demonstration on perineal/catheter care as part of their annual evaluation. All new Certified Nurse Aides upon hiring must complete a return demonstration on perineal/catheter care as part of their orientation. An in-service was held on October 16 th 2013 for all nursing staff on infection control related to hand-washing, gloving and catheter care. This in-service regarding infection control when doing		

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F 315	Continued From page 28 revealed 2. Gloves A.)Wear gloves (clean, non-sterile) when touching blood, body fluids, secretions, excretions, and contaminated items. B.) Put on clean gloves just before touching mucous membranes and non-intact skin. C.) Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. D.) Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. Wash hands immediately to avoid transfer of microorganisms to other residents or environments. Record review revealed the facility admitted Resident #3 on 01/03/13 with diagnoses which included Cystitis, Spinal Stenosis, Deficiency Anemia, unspecified Noninfectious Gastroenteritis and Colitis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/07/13 revealed the facility assessed Resident #3's cognition as moderately impaired and he/she required extensive assist of two (2) staff for hygiene and bathing. Observation on 09/27/13 at 10:35 AM of Certified Nursing Assistants (CNA) #8 and #14 providing perineal and catheter care to Resident #3 revealed the CNAs applied gloves and proceeded to touch the dresser, the closet door, the privacy curtains, the door, the bathroom door, the water faucet, the end of bed and the bedside table prior to providing perineal care/catheter care to the resident. The CNAs failed to remove their gloves and wash their hands and reapply a clean pair of gloves prior to providing care to the resident. Interview with CNA #8 and CNA #14, on 09/27/13	F 315	perineal/catheter care will be repeated annually by the Infection Control Nurse. An audit conducted by the Wound Care/Infection Control Nurse regarding all Certified Nurse Aides performing a return demonstration on gloving and hand-washing before and after perineal/catheter care has been completed. A weekly audit of 10 (ten) certified nurse aides (selected randomly) on demonstration on gloving and hand-washing before and after perineal/catheter care will be completed weekly for four weeks, and then monthly until 100% compliance is achieved then quarterly. This audit will be conducted as part of the facility's Quality Assurance Program.	

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F 315	Continued From page 29 at 11:40 AM, revealed they should have washed hands and changed gloves prior to providing care to Resident #3 after touching the table, doors, drawers, bath basin, trash bags, and bed because the contamination of gloves from other items could be passed to the resident. Interview with Licensed Practical Nurse (LPN) #4/Wound Care and Infection Control Nurse on 10/07/13 at 11:05 AM, revealed staff had been educated on them washing hands and changing gloves after touching other items in the room while providing care. LPN #4 stated the CNAs should have gathered the supplies they needed and set up everything prior to donning the gloves.	F 315			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure food was at the proper temperature. Observation of a meal revealed food was below the facility acceptable temperatures when served. The findings include: Review of the facility's policy on standard temperatures, not dated, revealed:	F 364	F 364 The food tray for Resident # 1 was reheated. Dietary Supervisor and Charge Nurses monitored tray carts for timeliness of arrival to dining room and distribution. All residents' food trays were reheated or replaced that complained of food too cold. Dietary Supervisor ordered an "Induction Charger System" from Direct Supply on October 25, 2013. The Induction Charger system will maintain all food trays at proper temperatures for up to 60 minutes. Also John Tomes the	11/20/2013	

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F 364	<p>Continued From page 30 Standard Temperatures</p> <table border="1"> <thead> <tr> <th>Food Item Standard</th> <th>Tray line Standard</th> <th>Bedside Standard</th> </tr> </thead> <tbody> <tr> <td>Meats degrees</td> <td>160-175 degrees</td> <td>140-160</td> </tr> <tr> <td>Vegetables degrees</td> <td>160-175 degrees</td> <td>150-170</td> </tr> <tr> <td>Liquids degrees</td> <td>170-190 degrees</td> <td>150-170</td> </tr> <tr> <td>Pureed food degrees</td> <td>140-150 degrees</td> <td>120-130</td> </tr> </tbody> </table> <p>Record review revealed the facility admitted Resident #1 on 12/03/2008 with diagnoses which included Dementia with Behavioral Disturbances, and Bipolar I Disorder. Interview with Resident #1, on 09/27/13 at 1:00 PM, revealed his/her food was always cold when it was served to him/her. Resident #1 stated he/she has sent his/her food back to have it warmed several times.</p> <p>Observation of the tray line, on 09/26/13 at 6:10 PM, revealed the following food temperatures: barbecue (BBQ) ribslets: 180 degrees Fahrenheit (F), brown gravy: 165 degrees F, mashed potatoes: 180 degrees F., fried potatoes: 165 degrees F., and peas and carrots: 165 degrees F.. Observation of the food cart, on 09/26/13 at 6:30 PM, revealed the food cart left the kitchen to the Church Hill dining room.</p> <p>Observation of the last tray on the food cart, on 09/26/13 at 6:45 PM, revealed the following food temperatures: BBQ ribslets: 120 degrees F., peas and carrots: 130 degrees F, mashed potatoes and gravy: 130 degrees F. and fried potatoes: 120 degrees F.</p>		Food Item Standard	Tray line Standard	Bedside Standard	Meats degrees	160-175 degrees	140-160	Vegetables degrees	160-175 degrees	150-170	Liquids degrees	170-190 degrees	150-170	Pureed food degrees	140-150 degrees	120-130	F 364	<p>facilities licensed electrician has been contacted to install a 240 volt receptacle for operating power.</p> <p>An audit conducted by the Dietary Supervisor/Assistant Dietary Supervisor was completed for all three meals on October 26, 2013. This audit consisted of observing a test tray for all three meals to ensure proper meal temperatures were being maintained. This audit will be conducted by the Dietary Supervisor or the Dietary Cook for all three meals per day until 100% compliance for one month is achieved. Then the audit will be conducted one meal per day every day for one month until 100% compliance. Then the audit will be conducted once per week until 100% compliance. Then the audit will be conducted once per month until 100% compliance. Then the audit will be conducted once per quarter until a deficient practice is discovered and will go back to daily audits until deficient practice is resolved. These audits will be conducted as part of the Facility's Quality Assurance Program.</p>	
Food Item Standard	Tray line Standard	Bedside Standard																		
Meats degrees	160-175 degrees	140-160																		
Vegetables degrees	160-175 degrees	150-170																		
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F 364	Continued From page 31 Interview with State Registered Nurse Aide (SRNA) #21, on 09/27/13 at 10:43 AM, revealed the residents sometimes complained about their food being cold and he/she warmed the food for them. Interview with SRNA #6, on 09/26/13 at 4:43 PM, revealed she had sent Resident #1's tray back to be rewarmed and has also had to ask for a replacement tray because the resident's food was too cold. Interview with the Dietary Supervisor, on 09/27/13 at 9:16 AM, revealed she had complained the food was cold. The Dietary Supervisor stated the temperatures that were taken at supper on 09/26/13 were not acceptable. Interview with the Director of Nursing, on 09/27/13 at 11:10 AM, revealed the food temperatures taken on 09/26/13 at supper, at the point of service, were not acceptable. Interview with the Administrator, on 09/27/13 at 11:29 AM, revealed if the residents were not happy with the food temperatures then changes needed to be made.	F 364			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	F 490 The alleged perpetrator was put on administrative leave on 9/27/13 and not	11/20/2013	

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F 490	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of the facility's Administrator's job description, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for one (1) of eight (8) sampled residents (Resident #1). On 08/10/13, the facility noted Resident #1 had an injury of unknown source to his/her left hand. There was no documented evidence the facility conducted an investigation of this injury. On 08/20/13, Adult Protective Services (APS) notified the facility's Social Service Director (SSD), who is the Abuse/Neglect Coordinator, and responsible for investigating allegations of abuse, that they were investigating an allegation of abuse that a staff member injured Resident #1. It was alleged staff pulled the resident, by his/her wrist down the hall, causing an injury. There was no documented evidence the facility initiated an investigation of abuse, protected the residents from the alleged perpetrator or notified the State Survey Agency (SSA), after this notification. Furthermore, the Administrator was made aware of the allegation of abuse on 09/25/13 but the Certified Nurse Aide (CNA) was not suspended and an investigation was not initiated until 09/27/13. Refer to F225 and F226.</p> <p>The facility's failure to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental and psychosocial well-being related to abuse allegations and an injury of unknown origin has caused or is likely to cause serious injury,</p>	F 490	<p>allowed to work with the resident #1. An investigation was started on 9/27/13 by the Social Services Director related to the allegation of abuse alleged on 8/20/13. The investigation was completed on 10/4/13. The employment of the alleged perpetrator was terminated on 10/4/13. The investigation on the injury of unknown origin identified on 8/10/13 on resident #1 was started by the Restorative Nurse on 9/27/13. It was determined that the bruise occurred on second shift on 8/9/13. It was noted on the electronic documentation on 8/9/13 that the resident was hitting, shoving and kicking at staff. No bruise was identified until 8/10/13.</p> <p>Audits were done by the Director of Nursing and Social Services Director on 10/3/13 with 27 interviewable resident's (those with a BIMS score of 8 or above) asking if they had been abused or mistreated. All 27 residents denied abuse. There were 38 residents who were not interviewable. All 38 residents were observed on 10/3/13 for signs and symptoms of abuse using observation of skin assessments, family interviews to detect changes or concerns. On 10/3/13 the Director of Nursing audited 104 incident reports for the past 3 months. To assess if any of the incident reports indicated any suspected abuse, mistreatment, neglect, and source of injury unknown or misappropriation of property and if any further investigation was needed. The</p>		

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F 490	Continued From page 33 harm, impairment or death to a resident. Immediate Jeopardy was identified, on 10/02/13, and determined to exist on 08/20/13, at 42 CFR 483.13 Resident Behavior and Facility Practice at F225 and F226, and 42 CFR 483.75 Administration at F490, at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of Immediate Jeopardy on 10/02/13. An acceptable Allegation of Compliance (AoC) was received on 10/08/13 alleging removal of the Immediate Jeopardy on 10/09/13. The State Survey Agency validated, on 10/09/13, the Immediate Jeopardy was removed on 10/09/13, as alleged. The scope and severity was lowered to a "D" at 42 CFR 483.13 Resident Behavior and Facility Practice with F225 and F226, and 42 CFR 483.75 Administration with F490 while the facility implements the Plan of Correction (PoC) and facility's Quality Assurance (QA) Audits are implemented and monitored for the effectiveness of system changes. The findings include: Review of the job description entitled, "Job Description and Performance Standards of the SSD", undated, revealed the SSD was responsible for the safety of residents under his/her supervision, and must observe all facility's policies and procedures. Review of the job description entitled, "Job Description and Performance Standards of the DON", undated, revealed the DON was responsible for directing, evaluating and supervising all resident care, to initiate corrective action as necessary, to assume responsibility for analysis of incident and accident investigation	F 490	audit included review of the incident reports, medical records and staff interviews if indicated. The Quality Assurance Nurse has reviewed 24 grievances reports on 10/3/13 to see if any of those would have been suggestive of abuse, neglect, mistreatment, or misappropriation of funds. This also included review of the grievance log as well as staff interviews. The Administrative staff (Administrator, Director of Nursing, Restorative Nurse, Business office Manager, Personnel Director, Laundry Manager, Activities Director, Environmental Director, Maintenance Director, RAI Nurses, Dietary Manager, Medical Records Manager, Social Services Director and QA/In-service Coordinator) was In-serviced on 10/8/13 by Kay Stevens, RN Nurse Consultant KAHCF Committee member on the Abuse, Neglect, Mistreatment and misappropriation of funds Policy which includes the seven components of the abuse prevention protocol. The Administrative staff was also required to take a post test with 100% accuracy. All staff was In-serviced 10/2/13 thru 10/4/13 on abuse, neglect, mistreatment and misappropriation of funds Policy which included the seven components of the abuse prevention protocol with the requirement that a 20 question test be passed with 100% accuracy. Our		

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F 490	Continued From page 34 reports to determine cause(s) and implement corrective action(s), when appropriate. Review of the job description entitled, "Job Description and Performance Standards of the Administrator", undated, revealed the Administrator was responsible to operate the facility in accordance with the established policies and procedures of the governing body in compliance with federal, state and local regulations; establish systems to ensure compliance with all federal, state, and local regulations, observe all facility policies and procedures and observe all facility safety policies and procedures. Review of facility's policy entitled, Reporting & Investigation of Abuse, Neglect, Mistreatment, Exploitation and/or Misappropriation of Resident Property, last revised 07/21/10, revealed: If an injury is noted and the source of the injury cannot be identified, the abuse investigation is started as described below with the goal of determining what caused the injury and ruling out any instance of abuse. The facility's Injury of Unknown Etiology Investigation Form will be started by the Social Service Director (SSD) or his or her designee after he/she is notified by a staff member or family member noting the injury. It is imperative that the injury be reported to the SSD, the Director of Nursing (DON) and the Administrator immediately. In addition, the policy and procedure revealed all personnel must immediately report an incident or suspected incident of resident abuse, neglect or mistreatment including injuries of an unknown source or misappropriation of resident property. Observation of an incident or resident abuse or suspecting resident abuse must be reported to	F 490	orientation program will now include in-service by the In-service Coordinator for all new employees before they are allowed to give direct care. This includes new hires or contract labor should we employ them. They will not be allowed to work unless they have passed the abuse test with 100% accuracy. An audit on interviewable residents (those with a BIMS score of 8 or above) asking them if they have been mistreated or abused will be done by the Social Services Director once a week for 8 weeks of 100% compliance. This audit will be continued for at least every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on non-interviewable residents (those with a BIMS score of below 8) observing them for signs and symptoms of abuse using skin assessments & family interviews. This audit will be done by the Social Services Director once a week for 8 weeks of 100% compliance. This audit will be continued for at least every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on incident reports will be done by the Director of Nursing weekly for 8 weeks of 100% compliance. This audit will be continued every month for 3 months, if 100% compliance continues random audits (ten) residents will continue quarterly. An audit on staff as to their understanding of		

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F 490	Continued From page 35 the charge nurse or supervisor and the DON/designee, SSD and Administrator should be notified immediately, with the investigation starting immediately. The resident should be removed from harm and examined and the examination recorded in the medical record. If the allegation of abuse is against a staff member, that person is to "leave the building immediately and will be denied unsupervised access to the residents", that staff is placed on administrative leave pending the outcome of the investigation. The Administrator or his/her designee is to immediately notify the State agency and the Adult Protective Services (APS) as required by state law. An immediate investigation will be made by the SSD and a copy of the findings will be provided to the Administrator or his/her designee per "Allegation of Abuse Investigation Form-Appendix E". The State agency is to be notified within five (5) working days of the occurrence. The Administrator or his/her designee will inform the resident and his/her legal representative of the results of the investigation and corrective action taken. Record review revealed the facility admitted Resident #1 on 05/13/13 with diagnoses which included Dementia, Symbolic Dysfunction, Muscular Wasting and Disuse Atrophy. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 08/16/13, revealed the facility assessed Resident #1's cognition as severely impaired and he/she required assistance with all activities of daily living. On 08/10/13, the facility noted Resident #1 had an injury of unknown source to his/her left hand. There was no documented evidence the facility conducted an investigation of this injury. On	F 490	the seven components of the abuse prevention protocol by the QA/In-service Coordinator will be done once a week for 8 weeks of 100% compliance. This audit will be continued for at least 6 months. An audit reviewing grievances by the QA/In-service Coordinator will be done once a week for 8 weeks of 100% compliance. This audit will be continued for at least 6 months. These audits will be conducted as part of the Facility's Quality Assurance Program.		

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F 490	<p>Continued From page 36</p> <p>08/20/13, Adult Protective Services (APS) notified the facility's Social Service Director (SSD), who is the Abuse/Neglect Coordinator, and responsible for investigating allegations of abuse, that they were investigating an allegation of abuse that a staff member injured Resident #1. It was alleged staff pulled the resident, by his/her wrist down the hall, causing an injury. There was no documented evidence the facility initiated an investigation of abuse, protected the residents from the alleged perpetrator or notified the State Survey Agency (SSA), after this notification.</p> <p>Interview with the SSD who is also the Abuse/Neglect Coordinator, on 09/30/13 at 12:50 PM, revealed she was aware of the bruise on Resident #1's hand because she had read about the bruise in the Nursing Notes. The SSD stated the facility's policy and procedure for abuse was staff should complete the Injury of Unknown Etiology Investigation form, an investigation should have been conducted to try to determine the cause of the injury and rule out abuse and the Administrator should have been notified. The SSD revealed the facility's policy and procedure was not followed.</p> <p>Further interview with the SSD, on 09/25/13 at 6:00 PM, on 09/27/13 at 11:00 AM and 2:15 PM, on 09/30/13 at 12:50 PM, and on 10/01/13 at 10:25 AM, revealed APS had made her aware on 08/20/13 that there was an allegation that a CNA had dragged Resident #1 down the hall by the resident's wrist. The SSD stated the facility's policy and procedure for an allegation of abuse was if an allegation was received against a staff member it was the facility's policy to have the staff member go to the conference room to take their statement and then send him/her home until</p>	F 490	

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F 490	Continued From page 37 the investigation was completed. The Administrator and DON should be notified and an investigation should be initiated immediately. The SSD stated the SSA and APS should be notified within twenty-four hours and the final investigation results should have been reported within five (5) days to the SSA. The SSD revealed an initial allegation form and allegation of Abuse Investigation form should be completed for the abuse allegation. The SSD revealed the facility's policy and procedure was not followed because staff failed to complete the forms. The SSD stated according to the facility's policy she should have notified the DON, Administrator and the SSA immediately, conducted a thorough investigation and determined if the allegation was or was not substantiated. The SSD stated APS unsubstantiated the allegation so she unsubstantiated it because "they are the experts". Interview with the DON, on 09/27/13 at 11:45 AM and 1:45 PM, and 09/30/13 at 2:39 PM revealed it was the facility's policy that the Administrator, SSD, and DON should be notified immediately if an allegation is made. The DON stated the resident should be removed from any suspected harm, the staff member should be suspended and walked out of the building by staff, an investigation should be initiated and the SSA should be notified immediately. The DON stated she was made aware of the allegation on 08/20/13 by the SSD who informed her an allegation had been made that a staff member had roughly handled Resident #1. The DON revealed the facility's policy and procedure was not followed related to notification of the SSA and completing a thorough investigation. The DON stated she, the Administrator and SSD were responsible to ensure an investigation was	F 490		

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F 490	<p>Continued From page 38 completed.</p> <p>Review of CNA #1's Employee Daily Activity Report revealed the facility allowed her to work twenty-six (26) days from 08/20/13 through 09/26/13. Interview with CNA #1, on 09/26/13 at 6:45 PM, revealed she was aware an allegation of abuse was made against her but she had not been placed on administrative leave.</p> <p>Interview with the Administrator, on 10/01/13 at 9:25 AM and 10/02/13 at 3:22 PM, revealed according to the abuse/neglect policy and procedure the SSD, Administrator, and DON should be notified of an allegation once a resident has been made safe; the suspected staff, witnesses and resident should be interviewed, and the suspected staff should be placed on administrative leave until the investigation was complete. The Administrator stated he was not aware of the allegation of abuse involving CNA #1 to Resident #1 until 09/25/13, and the SSD should have made him aware of the allegation. The Administrator further revealed CNA #1 was not placed on administrative leave and an investigation had not been initiated until 09/27/13. The Administrator stated he was 100% responsible for what goes on in the facility, and the SSD does not make the determination of the allegation on her own it is a joint effort.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 09/27/13, the alleged perpetrator was put on administrative leave and not allowed to work with residents and an investigation was initiated by the Social Services Director (SSD) related to the allegation of abuse involving Resident #1 and</p>	F 490			

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F 490	<p>Continued From page 39</p> <p>CNA #1. In addition, an investigation was initiated related to Resident #1's injury of unknown injury by a Restorative Nurse. The investigations involved staff interviews, record reviews, and review of electronic documentation. Subsequently, the alleged perpetrator was terminated on 10/04/13 for failure to get along with other staff.</p> <p>The SSD was trained on investigations of alleged abuse, mistreatment, neglect and misappropriation of funds by the Nurse Consultant on 10/08/13.</p> <p>The Administrative Staff (Administrator, DON, Restorative Nurse, Business Office Manager, Human Resources Manager, Laundry Manager, Activities Director, Environmental Director, Maintenance Director, RAI Nurses, Dietary Manager, Medical Record Manager, Social Service Director, and QA Inservice Coordinator) was inserviced by the RN Consultant on the Abuse, Neglect, Mistreatment and Misappropriation of Funds policy which include the seven components of the Abuse Prevention Protocol on 10/08/13. The staff was required to take a post test and receive 100% accuracy.</p> <p>All staff was inserviced on the Abuse Neglect, Mistreatment and Misappropriation of Funds policy including the seven (7) components of the Abuse Prevention Protocol on 10/02-10/04/13 by the QA/Inservice Coordinator/Nurse Aide Instructor. The staff was required to take a post test and pass with 100% accuracy. Staff involved in the policy inservice training included: nurses, certified medical assistants (CMA), CNAs, ward clerks, business office, nurse aides, activity workers, maintenance department, social</p>	F 490		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/09/2013
NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 606 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 40</p> <p>services, receptionist, environmental services department, laundry department, maintenance department, dietary department, and therapy.</p> <p>The orientation program will include an inservice on the Abuse Policy and the seven (7) criteria by the Inservice Director for all new employees before they were allowed to give direct care. This includes new hires, contract labor and agency staff if used. The new employees will be given a post test and must pass with 100% accuracy.</p> <p>On 10/03/13, the DON and SSD conducted audits with twenty-seven (27) interviewable residents (those with BIMs score of eight (8) and above) asking if they had been abused or mistreated with all residents denying abuse with no concerns noted. Non-interviewable residents were observed for signs and symptoms of abuse using observation of skin assessments, and family interviews to detect changes or concerns, with no concerns noted.</p> <p>A Quality Assurance (QA) audit was conducted on interviewable residents by the SSD asking if they have been mistreated or abused once a week for eight (8) weeks of 100% compliance and continued for at least six (6) months, with the QA audit being brought to and reviewed at quarterly and interim QA meetings by the Social Service Director. The audit will also include the thirty-eight (38) non-interviewable residents. They will be observed for signs and symptoms of abuse during weekly skin assessments and family interviews. This audit will be done once a week for eight weeks of 100 % compliance. This audit will be continued for at least three (3) months. If any issues are identified they will be immediately investigated. The QA audit will be</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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F 490	<p>Continued From page 41</p> <p>brought to and reviewed at quarterly and interim QA meetings by the Social Service Director.</p> <p>On 10/03/13, the DON audited one-hundred four (104) incident reports for the past three (3) months to assess for suspected abuse, mistreatment, neglect and source of injury unknown origin. The audit consisted of review of incident reports, medical records and staff/resident interviews if needed. If issues were identified they were investigated. This audit will continue at least monthly for three (3) months with 100% compliance with random audits continued quarterly.</p> <p>The QA nurse reviewed twenty four (24) grievances on 10/03/13 which consisted of review of grievance forms, grievance log and staff interviews to see if any would have been suggestive of abuse with no abuse noted. This audit will be done by the QA nurse once a week for eight (8) weeks of 100% compliance and be continued for at least six (6) months, with the audit being brought to and reviewed at quarterly and interim QA meetings by the QA nurse.</p> <p>The QA nurse will conduct an audit once a week for eight (8) weeks to establish the staff understands the seven (7) components of the abuse prevention protocol. The audit consist of interviewing staff on screening, training, prevention, identification, investigation protection, reporting and responding; with the audit being done once a week for eight (8) weeks of 100% compliance for at least six (6) months.</p> <p>The State Survey Agency validated the corrective action by the facility as follows:</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 490	<p>Continued From page 42</p> <p>Review on 10/08/13 of the activity audits of all departments revealed CNA #1 was not working in the facility from 09/27/13 through 10/05/13. Interview with the DON, on 10/09/13 at 9:00 AM, revealed CNA #1 had not worked at the facility since being put on administrative leave on 09/27/13.</p> <p>Review of the facility's inservices, dated 10/02/13 through 10/04/13 and 10/08/13, revealed all staff which included the Administrative staff was inserviced on the seven (7) components of the abuse prevention policy and an abuse test was given afterward with test scores of 100%. The Administrative staff also received an additional inservice by an Registered Nurse (RN) Consultant on the seven (7) components of the abuse prevention policy and an abuse test was given afterward with test scores of 100%.</p> <p>Interviews on 10/09/13 from 11:00 PM to 5:55 PM with fourteen (14) CNAs, six (6) nurses, three (3) Certified Medicine Aids (CMA), two (2) Therapy Aides, three (3) Dietary Aides, a Receptionist, a Ward Clerk/Medical Records, two (2) Minimum Data Set/Resident Assessment Instrument nurses, one (1) Maintenance, two (2) laundry aides, and six (6) Housekeeping Aides revealed they had received an inservice on the seven (7) components of abuse and had made 100 % on required test given by the Quality Assurance (QA)/Inservice Coordinator/Nurse Aide Instructor nurse from 10/02/13 through 10/04/13.</p> <p>Interviews on 10/09/13 at 1:00 PM through 5:00 PM with Administrative staff, to include the Administrator, DON, Restorative Nurse, Dietary Supervisor, Activity Director, SSD, Maintenance Director, Laundry Supervisor, Housekeeping</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 43</p> <p>Supervisor, and Business Office Manager revealed they had been inserviced on the seven (7) components of abuse and had made 100% on the required test. In addition the Administrative staff revealed they had received an additional inservice by an outside Nurse Consultant on 10/08/13 on the seven (7) components of abuse and had made 100% on the required test.</p> <p>Interview with the QA/Inservice Coordinator/Nurse Aide Instructor, on 10/09/13 at 2:00 PM revealed she will inservice new hires on the seven (7) components of abuse and the new hires will be required to take the test and make 100% before they will be allowed to work on the floor.</p> <p>Interview on 10/09/13 at 11:00 AM with the DON and QA/Inservice Coordinator/Nurse Aide Instructor revealed all staff had been inserviced on the seven (7) components of abuse and had made 100% on the required test. The DON and QA/Inservice Coordinator/Nurse Aide Instructor further revealed Administrative staff had received an additional inservice by an outside Nurse Consultant on 10/08/13 on the seven (7) components of abuse and had made 100% on the required test afterward.</p> <p>Review of QA Audits dated 10/09/13 revealed interviewable residents were interviewed by the SSD and she asked them if they had been mistreated or abused. The QA audit also included the thirty-eight (38) non-interviewable residents observed for signs and symptoms of abuse during weekly skin assessments and family interviews. Interview on 10/08/13 at 10:00 AM and on 10/09/13 at 12:20 PM with the SSD and DON revealed they completed the resident interviews with interviewable residents and family</p>	F 490			

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F 490	<p>Continued From page 44</p> <p>interview with non-interviewable residents' family. The SSD and DON stated they observed the residents to determine if there were any signs or symptoms of abuse.</p> <p>A review of the Incident Log Audit, on 10/09/13, revealed the audit had been completed. Interview on 10/09/13 at 12:45 PM with the DON revealed she had audited the incident log and would now be using the CQI form designated for review of event reports to adequately identify, investigate, screen, and follow up on potential abuse for future events and if issues were identified they would be investigated. This audit will continue at least monthly for three (3) months with 100% compliance with random audits continued quarterly with summarization being taken to QA meetings.</p> <p>Review of the CQI form for grievances, the Grievance Log and interview with the QA/Inservice Coordinator/Nurse Aide Instructor, on 10/09/13 at 3:00 PM revealed she utilized the CQI review to ensure grievances were resolved promptly and to ensure screening and follow up on suspected abuse. The audit will be completed by the QA nurse once a week for eight (8) weeks of 100% compliance and be continued for at least six (6) months, with the audit being brought to and reviewed at quarterly and Interim QA meetings by the QA nurse. In addition, the CQI review form was completed to ensure staff had an understanding and are compliant with the abuse policy related to screening, training, prevention, identifying, investigating, protection and reporting will be utilized at the facility.</p> <p>Record review for Residents #9, #10 and #11 revealed a bruise of unknown origin was</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 805 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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F 490	Continued From page 45 Identified on Resident #10 with the facility initiating an investigation and notification sent to the State agency. Record reviews for Resident #9 and Resident #11 revealed no concerns. Review of the audits and monitoring tools initiated for tracking the effectiveness of the implemented policy, revealed no concerns. Interviews with the DON, QA/Inservice Coordinator/Nurse Aide Instructor, and SSD on 10/09/13 revealed they would ensure the audits and monitoring would continue as stated in the Allegation of Compliance.	F 490			