

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

*Acceptable
PoC 7/17/14
on-site
revisit required*

PRINTED: 07/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/06/2014
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NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

AMENDED 07/02/14

An Abbreviated/Partial Extended Survey to investigate KY00021726 was initiated on 05/22/14 and concluded on 06/06/14. KY00021726 was substantiated with deficiencies identified. Immediate Jeopardy (IJ) was identified on 05/28/14 and was determined to exist on 04/27/14, with deficiencies cited at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225, F-226; 42 CFR 483.20 Resident Assessment, F-282; and 42 CFR 483.75 Administration, F-490 and F-520, all at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of the Immediate Jeopardy on 05/28/14.

Based on the findings of the Abbreviated Survey, it was determined the facility had an ineffective system to monitor abusive residents and protect other residents from abuse. On 04/27/14, an initial Incident Report revealed Resident #3 reported to staff that Resident #1 had "touched" him/her on the leg under his/her "dress" twice, and he/she was afraid of Resident #1. The Incident Report noted Resident #1 was to be "under close watch by staff during the investigation". Additionally, the Incident Report revealed the Director of Nursing (DON) and Administrator were notified. Review of Resident #1's Comprehensive Care Plan revealed an intervention dated 04/28/14 for Resident #1 to be on every fifteen (15) minute checks; however, record review revealed no documented evidence the intervention was implemented on 04/28/14.

RECEIVED
JUL 17 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 7/17/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000 Continued From page 1

Record review from 04/28/14 through 05/10/14, revealed the checks were not completed every fifteen (15) minutes, the sheets were undated and there was no documentation the fifteen (15) minute checks had been done on several days. Interviews with nurses revealed they were not aware Resident #1 was on every fifteen (15) minute checks after the incident on 04/27/14. Certified Nursing Assistants (CNAs) reported they had not been informed of Resident #1's sexually abusive behavior and were not aware the resident was to be on every fifteen (15) minute checks. Interview with the DON revealed she was not certain when the fifteen (15) minute checks were to have started and was not aware the checks were not completed timely and had not been documented on several days.

On 05/10/14 at 1:25 PM the Housekeeping Manager witnessed Resident #1 "groping" Resident #2 between the legs. Resident #1 was then placed on one on one (1:1) supervision and transferred to another facility for further evaluation. Resident #1 was discharged and was not a resident of the facility during the survey.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 06/05/14, with the facility alleging removal of the Immediate Jeopardy on 06/04/14. The State Survey Agency validated the Immediate Jeopardy was removed on 06/04/14 as alleged with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225, F-226; 42 CFR 483.20 Resident Assessment, F-282; and 42 CFR 483.75 Administration, F-490, at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program monitors to

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F 000	Continued From page 2	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>		
F 223 SS=J	<p>ensure resident are free from abuse.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's Fax/Incident Reports and policies, it was determined the facility failed to have an effective system to ensure residents remained free from abuse for two (2) of ten (10) sampled residents (Residents #2 and #3).</p> <p>Review of the initial Fax/Incident Report dated 04/27/14, revealed Resident #3 told staff he/she was afraid of Resident #1 who had "touched" him/her on the leg under his/her "dress" twice. Continued review of the Fax/Incident Report revealed Resident #1 was to be "under close watch", and the Director of Nursing (DON) and Administrator had been notified. However, there was no documented evidence the facility implemented interventions on 04/27/14 to protect other residents from potential abuse. Review of Resident #1's Comprehensive Care Plan revealed on 04/28/14 an intervention was added for the resident to be on every fifteen (15) minute checks. However, record review revealed no documented evidence the intervention was</p>	F 223		<p>F223</p> <ol style="list-style-type: none"> All residents are at risk for abuse due to physical dependency, decreased cognition, and decreased mobility. All staff will be in-serviced on how to recognize the signs and symptoms of abuse. New protocol has been developed to ensure that potential abusers are identified and interventions are implemented in an attempt to prevent resident to resident abuse. All residents were evaluated for potential to be an abuser. This was completed on 7/3/14 by the DON, Assistant Director of Nursing, Staff Development RN, and/or RN Supervisor. Information from the evaluation determines if additional assessment and interventions are necessary for each resident in the center. Appropriate interventions were implemented and Care Plans updated on 7/3/14 initially by DON, Assistant Director of Nursing, Staff Development RN and thereafter RN Unit Managers and Charge Nurse. If resident to resident allegation occurs; remove aggressor from the 	

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 implemented on 04/28/14. Continued record review revealed from 04/28/14 through 05/10/14, documentation of the every fifteen (15) minute checks was incomplete and/or undated. Interviews with Certified Nursing Assistants (CNAs) revealed they were not informed of Resident #1 being sexually abusive to Resident #3. Interviews with nurses and CNAs revealed they were not aware Resident #1 had been placed on every fifteen (15) minute checks on 04/28/14. As a result of the facility's failure to monitor Resident #1, other residents were not protected from potential abuse. On 05/10/14, the resident was observed by a staff person to be "groping" another resident, Resident #2, between the legs. Resident #1 was placed on one to one (1:1) supervision and transferred to another facility for further evaluation.

The facility's failure to have an effective system in place to ensure residents remained free from abuse was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 05/28/14 and was determined to exist on 04/27/14. The facility was notified of the Immediate Jeopardy on 05/28/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 06/05/14, with the facility alleging removal of the Immediate Jeopardy on 06/04/14. The Immediate Jeopardy was verified to be removed on 06/04/14 as alleged with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program monitors to ensure residents are free from abuse.

F 223: *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

situation and place on continuous observation until otherwise notified by DON and/or Administrator. Documentation is to be done at the beginning of the observation and throughout. Education was completed by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. Administrator and DON educated Assistant Director of Nursing, Staff Development RN, RN Unit Manager, Shift Supervisors, and Weekend Supervisor as to the purpose of the Abuse Investigation Checklist and use of this tool with completion by 7/3/14. Administrator and DON will monitor use of checklist with every abuse investigation as needed. Licensed Nursing staff were in-serviced on assessments, performing an assessment, interventions, and the update and use of care plans. Education was conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. Licensed Nursing

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F 223	Continued From page 4 The findings include: Review of the facility's policy titled, "Abuse Resident to Resident", effective October 2012, revealed all residents had the right to be free from any mental or physical mistreatment. Immediate action was to be taken in any occurrence of a resident to resident altercation with immediate interventions taken to prevent reoccurrence. Continued review of the policy revealed measures included monitoring of residents at the nurses station, one on one (1:1) therapy/activity, and discharge to the hospital for medical evaluation if necessary. Review of the facility's Fax/Incident Report dated 04/27/14 which was faxed to the State Survey Agency revealed Resident #3 told a nurse Resident #1 had "touched" him/her on the leg under his/her "dress" two (2) times and he/she was afraid of Resident #1. Further review of the Report revealed Resident #3 was placed "under close watch" and preventative measures were taken to keep Resident #1 under watch by staff during the investigation. Review of the final five (5) day investigation results Fax/Incident Report dated 05/01/14, for the 04/27/14 incident, revealed "follow-up" with Resident #3 revealed the resident did not recall the incident and had "shown no catastrophic reaction" after the incident. Further review of the final five (5) day Fax/Incident Report revealed Resident #1 denied the incident, was seen by the Psychiatrist, and the facility was to continue to monitor "the situation". Review of the Nurse's Note dated 04/27/14 at 2:21 PM, documented as a "late entry" Note for	F 223	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> staff were in-serviced on the implementation and use of Care Plans. Education was conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. Licensed Nursing staff were in-serviced on components of accurate and thorough shift reporting. Education was conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. All staff were in serviced on abuse, what it is, and the reporting, with a focus on resident to resident sexual aggressiveness. Education was conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. All staff was in serviced on Resident Rights. Education was conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. No agency in use at the facility. All new hires will be educated during		

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9:15 AM that morning, revealed a resident reported Resident #1 had made inappropriate advances at him/her. Continued review of the Note revealed the resident stated Resident #1 had reached up his/her "dress" and attempted to touch him/her. The resident reported this had happened yesterday (04/26/14) and also on a previous day.

Review of Licensed Practical Nurse (LPN) #3's written statement, included in the facility's investigation, revealed on 04/27/14 at 9:20 AM, Registered Nurse (RN) #2 informed her Resident #3 told her Resident #1 "tried to touch" him/her on the leg. LPN #3 documented she notified the Director of Nursing (DON) who informed her to interview Resident #3 which she did. LPN #3 noted Resident #3 told her "the big" man/woman had "touched" him/her two (2) times, "putting" a "hand under" his/her gown and reached "more than halfway above" his/her knees on the inner thigh. Further review of the LPN #3's written statement revealed Resident #3 told her he/she was "afraid" of Resident #1 and the "last time" Resident #1 had "touched" him/her was on 04/26/14.

Interview, on 05/27/14 at 10:00 AM, with RN #2 revealed she had worked on 04/27/14, and Resident #3 had told her Resident #1 touched him/her. RN #2 stated she told the House Supervisor what Resident #3 reported to her.

Interview with LPN #3 on 05/27/14 at 12:30 PM, revealed she was the House Supervisor on 04/27/14. LPN #3 stated she was informed of the incident involving Residents #1 and #3 on 04/27/14. She indicated she called the DON who told her to start the investigation by collecting

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general orientation by the Staff Development RN. QA Committee members reviewed minimally 5 days a week for 30 days or additionally as necessary until 7/21/14; then one time weekly until 8/21/14 or as needed; then monthly thereafter or as needed sooner.

4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the Medical Director Quarterly. Next meeting with Medical Director will be held in July. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.

5. Date of Compliance: 7/7/14

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interviews and to notify the Physician. LPN #3 stated she called the Physician who gave an order to send Resident #1 to the local hospital's Behavioral Unit; however, the Behavioral Unit was full and could not accept the resident. Continued interview revealed she did not ensure the Certified Nursing Assistant (CNA) Worksheets were updated for the CNAs to watch Resident #1 for sexual behavior towards other residents.

Interview with CNA #2, on 5/23/14 at 2:50 PM, revealed Resident #3 told her on 04/27/14 that Resident #1 had touched his/her legs and pointed at Resident #1. CNA #2 asked Resident #3 if he/she was okay and the resident replied "no". According to CNA #2, Resident #3 told her Resident #1 put his/her hand up his/her dress, but he/she stopped Resident #1. CNA #1 said she told the Charge Nurse, Registered Nurse (RN) #2, immediately. The CNA stated there was no documentation on the CNA worksheets about Resident #1 having sexual behaviors and the CNAs were only told to "keep an eye on" Resident #1.

Interview with CNA #1 on 05/23/14 at 2:30 PM, with CNA #3 on 05/29/14 at 7:15 PM, and with CNA #4 on 05/29/14 at 7:15 PM, revealed nurses had not informed them of Resident #1's sexually abusive behavior toward Resident #3. They stated other CNAs had told them to "watch out for" and "keep an eye on" Resident #1.

Interview with CNA #5, on 05/29/14 at 7:00 PM, revealed one (1) time Charge Nurse #12 told her to keep an "eye on" Resident #1 because he/she had tried to put his/her "hand up" Resident #3's "dress".

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F 223	<p>Continued From page 7</p> <p>Interview, on 05/23/14 at 3:30 PM, with Registered Nurse (RN) #1, Second Shift House Supervisor, revealed she was told when she worked as the House Supervisor that Resident #1 was "following a lady around"; however, she did not remember the resident's name. RN #1 revealed she was unaware that Resident #1 had sexual behaviors towards other residents.</p> <p>Interview with the Director of Nursing (DON) on 5/22/14 at 3:00 PM, revealed Resident #1 had experienced increased behavior disturbances prior to 04/27/14. The DON stated she was uncertain if she had told the House Supervisor (HS), LPN #3 to start fifteen (15) minute checks on Resident #1 on 04/27/14, after the HS called her at home to report the incident involving Resident #3. She stated she was uncertain when Resident #1 was put on the fifteen (15) minute checks.</p> <p>Review of the medical record revealed Resident #3 was admitted by the facility on 01/17/14, with diagnoses which included Dementia with Behavior Disturbances and Presenile Depression. Review of the Annual Minimum Data Set (MDS) Assessment, 03/17/14, revealed the facility assessed Resident #3 to have A Brief Mental Status (BIMS) score of three (3) which indicated the resident was severely cognitively impaired.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 04/16/13, with diagnoses which included Dementia with Behavior Disorder and Confusion. Review of the Quarterly MDS Assessment dated 03/16/14, revealed the facility assessed Resident #1 to have a BIMS score of nine (9) which indicated the</p>	F 223		

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resident was moderately cognitively impaired. F 223

Review of Resident #1's Comprehensive Care Plan revealed an intervention was added on 04/28/14 for the resident to be on every fifteen (15) minute checks. However, review of the facility's documentation of the fifteen (15) minute checks for Resident #1, for the period of 04/28/14 through 05/10/14, revealed some of the check sheets were undated and there was inconsistent documentation of the checks. Additionally, review of the fifteen (15) minute check sheets revealed no documented evidence the checks were completed on several days between the dates of 04/28/14 and 05/10/14.

Continued review of the Nurse's Note dated 05/10/14 at 2:46 PM, revealed it was a "late entry" Note and at 1:20 PM a staff member reported Resident #1 inappropriately touching another resident, Resident #2.

Review of the facility's Fax/Incident Report dated 05/10/14, which was sent to the State Survey Agency, revealed on 05/10/14 at 1:30 PM a staff member observed Resident #1 with his/her hand between Resident #2's legs while both were sitting in the hallway.

Interview, on 05/23/14 at 10:15 AM, with the Housekeeping Manager (HM) revealed he witnessed Resident #1 rubbing Resident #2's "crotch" area on 05/10/14. He stated both residents were sitting in their wheelchairs in the hallway and Resident #2's eyes were closed. The HM reported Resident #2 opened his/her eyes when he asked Resident #1 what he/she was doing.

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Interview, on 05/24/14 at 4:30 PM, with RN #2 revealed on 05/10/14 the HM reported to her Resident #1 was "groping" Resident #2 in the "vagina area". Per interview, she thought Resident #1 might have been placed on fifteen (15) minutes checks a couple of days before the incident on 05/10/14 with Resident #2, but she was not sure.

Further review of Resident #1's record revealed a Nurse's Notes for 05/10/14 at 2:46 PM, (late entry for 1:20 PM) which noted "a staff member assigned for one to one monitoring" of the resident and the Power of Attorney (POA) and Physician were notified. Review of the Nurse's Note for 05/10/14 at 6:05 PM revealed the Physician had called with a new order received to send Resident #1 out to the emergency room (ER) for evaluation and treatment.

Telephone interview with Resident #1's Psychiatrist on 05/23/14 at 4:35 PM, revealed he did not send the resident out of the facility for the incident on 04/27/14, because the resident's niece did not want him/her sent out of the facility. The Psychiatrist stated it was "not surprising" Resident #1 would "behave sexually inappropriate". According to the Psychiatrist, Resident #1 had a problem with "impulse control" given his/her history. He stated Resident #1 "cannot be fixed". Continued interview revealed he was aware Resident #1 had exhibited verbal and "sexually inappropriate behavior" at the facility in the past towards staff and residents. However, he was "unsure" if Resident #1 had ever been physically sexual towards another resident.

However, interview with Resident #1's niece and

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Power of Attorney (POA), revealed the facility did not "approach" her about sending the resident out of the facility on 04/27/14 after the incident. She stated she had never personally spoken to the Psychiatrist.

Interview with the DON on 5/29/14 at 7:25 PM revealed interventions should have been put in place to protect Resident #2 and Resident #3, and to observe how they were coping after the incidents involving Resident #1. The DON stated it was her responsibility to ensure all staff was informed of incidents of abuse. However, staff interviews revealed this was not done.

Interview with the Administrator on 05/29/14 at 7:30 PM, revealed he was aware Resident #1's behaviors had exacerbated and was looking for placement for the resident elsewhere.

The facility provided an acceptable credible AOC on 06/05/14 that alleged removal of the IJ effective 06/04/14. Review of the AOC revealed the facility implemented the following:

1. The Administrator, DON, ADON and SDN were educated on 05/30/14 by the Regional Director of Operations for Preferred Care Partners, Management Group on Accidents and Supervision on residents must be free from abuse and neglect in order to ensure residents' were protected.
2. The Quality Assurance (QA) Committee reviewed all educational materials and developed a data collection tool on 05/30/14 to validate assessments and Care Plans were being utilized per policy protocol. The tool includes a monitor for aggressive resident behaviors. If aggressive

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F 223	<p>Continued From page 11</p> <p>behavior occurs, interventions implemented will be reviewed for effectiveness and a determination if additional interventions are needed will be made. The tool was implemented on 05/30/14 and is ongoing.</p> <p>3. Resident #3 had a weekly skin assessment completed on 05/03/14, and Resident #2 had a weekly skin assessments completed on 05/16/14. All residents were assessed for the potential to be an abuser, assessments were completed by 06/03/14. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Staff Development Nurse (SDN), and/or the Registered Nurse (RN) Supervisor completed the assessments. Information obtained was used to develop and implement appropriate interventions, and the Care Plans were updated initially by the DON, ADON or the SDN, and will be updated thereafter by RN Unit Managers and Charge Nurses.</p> <p>4. For any resident to resident allegations, the aggressor is to be removed from the situation and placed on continuous observation until otherwise notified by the DON and/or the Administrator. CNAs will be notified of the continuous observation order via the CNA Care Plan and "Accunurse" (the CNA computer documentation system). Nurses and CNAs were educated on the process by the DON, ADON or SDN, with the education completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. The facility does not use agency staff.</p> <p>5. The Administrator and the DON educated the ADON, SDN, RN Unit Managers, Shift Supervisors and Weekend Supervisors on the</p>	F 223		

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use of the Abuse Investigation Checklist tool, with the education completed by 06/03/14. The Administrator and the DON will monitor use of the checklist for every abuse investigation. The facility's general orientation for new hires was revised to include the education.

6. Licensed nursing staff were educated on performing assessments, interventions and updating the Care Plan, implementation and use of the Care Plan, the components of accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. The education was provided by the DON, ADON and SDN, and completed by 06/03/14. The facility's general orientation for new hires was revised to include the education.

7. All facility staff were educated on identifying and reporting abuse, with a focus on resident to resident sexual aggression, and on resident rights. The education was provided by the DON, ADON and SDN, and was completed by 06/03/14. The facility's general orientation for new hires was revised to include the education.

8. The Administrator or the DON will notify the Office of Inspector General, Adult Protective Services, the Ombudsman, and local law enforcement of all sexually aggressive behaviors as required by law and within specified time limits.

9. Educational records will be maintained and will include signatures of attendance, signatures of the education received, and copies of tests designed to determine the effectiveness of the education initiated on 05/30/14 and completed by 06/03/14.

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F 223	Continued From page 13 10. The Administrator is charged to administer the facility in a safe and efficient manner to assure the safety of the residents at all times. The Administrator, in conjunction with the DON, ADON and SDN, will assure education is provided and resident care and treatment is delivered in accordance with the Care Plan. Continued evaluation, assessment and Care Plan updates will be used to ensure all residents are safe from harm. 11. Monitoring and utilizing the (QA) Committee data collection tool developed on 05/30/14, is done by the DON, ADON, SDN, RN Unit Managers and RN Supervisors. QA meetings to review the collected data will be held five (5) days per week, and as needed, for thirty (30) days, then weekly for thirty (30) days, then monthly or as needed thereafter. Any identified concerns will be corrected immediately. The State Agency validated the implementation of the facility's AOC as follows: 1. Review of the education sign-in sheets revealed the Administrator, DON, ADON and SDN were educated by the Regional Director of Operations on 05/30/14, prior to the administrative team conducting education of all facility staff. Continued review revealed topics covered included supervision of incidents/accidents; abuse reporting; conducting investigations, and reviewing residents who are at risk or cognitively impaired. Interview with the Administrator, on 06/06/14 at 1:30 PM, revealed the Regional Director of Operations performed the education for the DON, ADON, SDN and himself on 05/30/14. The	F 223			

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Administrator stated the education was to ensure all residents were free from abuse and the facility was administered in a manner to assist residents to achieve their highest physical, mental and psychosocial well-being.

2. Review of the data collection tool developed by the QA Committee revealed it included, but was not limited to, validation of assessments completed, use of Care Plans, and a monitor of resident behaviors. In addition, in the case of aggressive behaviors, the tool allowed for a review of current interventions for effectiveness and a determination of the need for additional interventions.

Interview with the DON and the Administrator, on 06/05/14 at 4:45 PM, revealed the tool was developed and implemented on 05/30/14, and was being used as outlined in the AOC ongoing.

3. Review of Resident #3's record revealed a weekly skin assessment was completed on 05/03/14, with no documented evidence of physical injury. Review of Resident #2's record revealed a weekly skin assessment was completed on 05/16/14, with no documented evidence of physical injury.

Review of the facility's implementation documentation binder for the AOC revealed all residents were assessed, care plans were reviewed and updated for residents with identified behaviors, as alleged by the DON, ADON, SDN and RN Supervisor.

Interview with the DON, on 06/05/14 at 2:20 PM, revealed she reviewed Resident #3's weekly skin assessment dated 05/03/14, and Resident #2's

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F 223	Continued From page 15 weekly skin assessment dated 05/16/14 and confirmed the residents had no physical injuries documented on those dates. The DON stated all residents in the facility were assessed, and those with behaviors were monitored for the potential to be an abuser, care planned for the behaviors, and any behaviors were documented every shift. In addition, all new admissions were assessed for any history of behaviors and care planned accordingly. 4. Review of the facility's implementation documentation binder for the AOC revealed staff signatures of nurses and CNAs who received the education on residents on continuous supervision, updating and following residents' care plans, use of the Abuse Allegation Checklist and completed post-tests successfully. Continued review revealed all education was provided on or prior to 06/03/14 as alleged. Review of the Abuse Allegation Checklist form utilized by the facility revealed it included removing the aggressor resident and placing the resident on continuous observation. Review of the QA Data Collection tool revealed monitoring included whether staff used the Abuse Allegation Checklist after each incident. Review of the ongoing investigation file for the only resident to resident incident after implementation of the AOC revealed the Abuse Allegation Checklist was used, the aggressor resident was removed from the situation, and 1:1 supervision was initiated and thoroughly documented on. Review of the CNA Worksheet/Care Plan for the resident aggressor revealed it was updated to reflect the increased supervision.	F 223			

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Interviews 06/05/14 with CNA #6 at 2:45 PM; CNA #7 at 3:40 PM; and CNA #8 at 3:45 PM, revealed the CNAs education on residents on continuous supervision would be in the "Accunurse" computer system and on the CNA Worksheet/Care Plan. The CNAs reported receiving education related to providing the one on one (1:1) supervision and ensuring they documented the continuous supervision.

Interviews 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and, LPN #9 at 3:35 PM, revealed the nurses were educated on use of the Abuse Allegation Checklist, and updating and ensuring the CNAs and they followed residents' care plans.

5. Review of the facility's implementation documentation binder for the AOC revealed education sign-in sheets and post-tests for the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors who attended the education provided by the Administrator and DON.

Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they educated the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist, on or before 06/03/14. The Administrator and DON stated they were monitoring for use of the Checklist with every abuse investigation. They reported the education had been added to the facility's general orientation for new hires.

Interview with RN Supervisor #1, on 06/05/14 at

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F 223	Continued From page 17 3:15 PM, revealed she had received the education provided, took a post-test and was knowledgeable about when and how to use the Abuse Investigation Checklist. 6. Review of the facility's implementation documentation binder for the AOC revealed licensed nursing staff received mandatory education related to performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. Review of the Sign-in sheets reflected the nurses' attendance, and their completion of the post-tests which cross-matched with the signatures. Continued review revealed all education was received on or prior to 06/03/14 by the DON, ADON and SDN. Interviews on 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and LPN #9 at 3:35 PM, revealed the nurses confirmed receiving the education on performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents and had taken the post-test afterwards. Interview with the DON on 06/06/14 at 4:45 PM, revealed the education had been provided prior to 06/03/14 as per the AOC for all licensed nursing staff. The DON stated the education had been added to the facility's general orientation for new hires. 7. Review of the facility's implementation	F 223			

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documentation binder for the AOC revealed all facility staff had received education on abuse which included identifying and reporting abuse, resident to resident sexual aggression and Resident Rights. Continued review of the binder revealed a master list of employees, education sign-in sheets and post-tests which were cross-referenced to confirm the education.

Interview with the SDN on 06/05/14 at 4:30 PM, revealed she had participated in providing education for all facility staff related to abuse and Resident Rights. She stated each Department Head had a list of all staff who still needed to receive the education prior to returning to work and ensured the education was provided before the employee was allowed to work.

Interview with the DON, on 06/06/14 at 4:45 PM, revealed the facility ensured all facility staff received the mandatory education on abuse and Resident Rights, as per the AOC, by maintaining a master list of all staff and checking off names as they received the education. She stated a list of all staff on vacation or other leave included their return to work date, and no staff were allowed to be on duty prior to the education being completed.

Interviews on 06/05/14 with: Dietary Personnel #1 at 2:00 PM, Dietary Personnel #2 at 2:05 PM; Maintenance Assistant #1 at 2:15 PM; Social Services (SS) Assistant #1 at 2:18 PM; Laundry Personnel #1 at 2:20 PM; Occupational Therapist (OT) #1 at 2:23 PM; LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; CNA #6 at 2:45 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; LPN #9 at 3:35 PM; CNA #7 at 3:40 PM; and, CNA #8 at 3:45 PM

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F 223	<p>Continued From page 19</p> <p>revealed they all had attended the mandatory inservices related to abuse and Resident Rights. Those interviewed were able to explain their responsibilities if abuse were observed, reported or suspected. All interviewees were cross-checked to the education sign-in sheets and post-tests.</p> <p>8. Review of the facility's implementation documentation binder for the AOC revealed an ongoing investigation of a resident to resident altercation, which was not sexual in nature. Review of the investigation documentation revealed all required notifications were made timely in accordance with facility policy and federal and state regulations.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they would ensure notification of the State Survey Agency, Adult Protective Services, the Ombudsman and local law enforcement of all sexually aggressive behaviors as indicated in the AOC. However, they reported no incidents of sexually aggressive behaviors had occurred since the alleged date of compliance, 06/04/14.</p> <p>9. Review of the facility's implementation documentation binder for the AOC revealed education records included sign-in sheets for all education provided. Continued review revealed staff members were checked off from a master list of all employees in order for the facility to ensure every staff member received the education prior to returning to work. In addition, copies of completed post-tests were available for review and were cross-checked with the sign-in sheets. A review of educational offering agendas revealed all topics included in the AOC were</p>	F 223			

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F 223	Continued From page 20 provided. Further review revealed all education was completed prior to or on 06/03/14 as alleged. Interview with the Administrator and the DON on 06/05/14 at 4:45 PM, revealed all the education was mandatory with records being maintained. Interview with the SDN, on 06/05/14 at 4:30 PM, revealed she tracked employee attendance via the sign-in sheets and the master list. She stated she tried to make the inservices interesting to maintain the learners' attention, and utilized post-tests to verify effectiveness of the education. 10. Interview with the Administrator and the DON on 06/06/14 at 1:30 PM, revealed the Administrator was responsible for the overall administration of the facility. He stated his goal was to ensure every resident was safe and staff were knowledgeable regarding providing care according to the written Care Plan. He further stated he had been closely involved with the DON throughout the development and implementation of the AOC, including the monitoring of data collected as part of the QA process. The Administrator stated he and the DON ensured the education was provided. He indicated the facility would continue to evaluate, assess and update residents' Care Plans to ensure all residents were safe from harm. Both the Administrator and the DON stated every action outlined in the AOC had been conducted as alleged. 11. Review of the facility's implementation documentation binder for the AOC revealed residents' behaviors were documented by staff every shift. Continued review revealed QA team members reviewed the collected data daily Monday through Friday.	F 223			

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NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018		
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F 223	Continued From page 21 Interview with the DON revealed she reviewed all documented behaviors daily Monday through Friday to ensure the Care Plans were revised to include new interventions as indicated by the exhibited behavior. She stated the data is collected by her, the ADON, SDN, RN Unit Managers and RN Supervisors, with all behaviors reviewed by her.	F 223	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F225 1. All residents are at risk for abuse due to physical dependency, decreased cognition, and decreased mobility. 2. All residents were evaluated for the potential to abuse upon admission and with significant change in behavior by the admitting LPN/RN and Unit Manager. Information from the evaluation determines if additional assessment and interventions would be necessary for each resident in the center. Appropriate interventions will be implemented and Care Plans updated on 7/3/14 initially by DON, Assistant Director of Nursing, Staff Development RN and thereafter RN Unit Managers and Charge Nurse. 3. An Abuse Investigation Checklist was developed by QA Committee on 5/30/14 to be used when allegations of abuse occur. Staff responsible for the use of this checklist include the Unit Manager, Supervisor, Administrative RN's or Administrator. Administrator and DON educated Assistant Director		

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F 225	<p>Continued From page 22</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Fax/Incident Reports, investigation, and policies, it was determined the facility failed to have an effective system in place to ensure allegations of resident to resident sexual abuse were investigated thoroughly, and to ensure residents were protected from further abuse. The facility's failure affected two (2) of ten (10) sampled residents (Residents #2 and #3).</p> <p>On 04/27/14, Resident #3 reported being touched on the inner thigh under his/her clothes by Resident #1. Resident #3 reported the incident occurred on 04/26/14. The facility initiated their investigation of the incident immediately; however, their actions did not include a physical assessment of Resident #3 for possible injury. Although cognitively intact residents on the unit were interviewed by the facility, non-interviewable residents were not assessed for signs of possible abuse. In addition, the facility revised Resident #1's plan of care to implemented visual checks of the resident every fifteen (15) minutes; however, review of documentation and interviews with staff revealed the checks were not conducted consistently. As a result of the facility's failure to monitor Resident #1, other residents were not</p>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>of Nursing, Staff Development RN, RN Unit Manager, Shift Supervisors, and Weekend Supervisor as to the purpose of the Abuse Investigation Checklist and use of this tool with completion by 7/3/14. Administrator and DON monitor use of checklist with every abuse investigation as needed. Licensed Nursing staff to be in-serviced on components of accurate and thorough shift reporting. Education was conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. Licensed Nursing staff to be in-serviced on identification, documentation, and interventions related to abuse allegations. Education was completed by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. All staff were in-serviced on abuse, what it is, and the reporting, with a focus on resident to resident sexual aggressiveness. Education will be conducted by DON, Assistant</p>		

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protected from potential abuse. On 05/10/14, a staff member observed Resident #1 to have his/her hand between Resident #2's legs. Resident #1 was placed on 1:1 supervision at that time, until transferred to the hospital for further evaluation. The resident was discharged from the facility prior to initiation of the survey, and was not available for observation or interview. (Refer to F-223)

The facility's failure to have an effective system in place to ensure allegations of resident to resident sexual abuse were investigated thoroughly, and to ensure residents were protected from further abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 05/28/14 and was determined to exist on 04/27/14. The facility was notified of the Immediate Jeopardy on 05/28/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 06/05/14, with the facility alleging removal of the Immediate Jeopardy on 06/04/14. The Immediate Jeopardy was verified to be removed on 06/04/14 as alleged with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-225 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program monitors to ensure residents are free from abuse.

The findings include:

Review of the facility's policy, titled "Abuse Resident to Resident" (effective October 2012), revealed all residents had the right to be free from any mental or physical mistreatment. In response

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This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Director of Nursing, and Staff Development RN with a completion date of 7/3/14. All staff were in-serviced on Resident Rights. Education will be conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. No agency in use at the facility. All new hires will be educated during general orientation by the Staff Development RN. QA Committee members will review minimally 5 days a week for 30 days or additionally as necessary until 7/21/14, then one time weekly until 8/21/14 or as needed, then monthly thereafter or as needed sooner.

4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the Medical Director Quarterly. Next meeting with Medical Director will be held in July. The Quality Assurance Committee consists of

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F 225	<p>Continued From page 24</p> <p>to a resident to resident altercation, the facility was to take immediate action to prevent a reoccurrence of the behavior. Continued review of the policy revealed measures included, but were not limited to, monitoring of residents at the nurses station, one on one (1:1) therapy/activity, and discharge to the hospital for a medical evaluation if necessary. Further review of the policy revealed it did not address specific measures to ensure a thorough investigation was conducted, e.g. conducting physical assessments of victim residents or other vulnerable non-interviewable residents.</p> <p>Review of the facility's Fax/Incident Report, dated 04/27/14 and faxed to the State Survey Agency, revealed Resident #3 told a nurse Resident #1 had "touched" him/her on the leg under his/her "dress" two (2) times and he/she was afraid of Resident #1. Further review of the Report revealed preventive measures were taken to keep Resident #1 under watch by staff during the investigation.</p> <p>Review of Licensed Practical Nurse (LPN) #3's written statement, included in the facility's investigation, revealed on 04/27/14 at 9:20 AM, she was informed by Registered Nurse (RN) #2 of an allegation by Resident #3 that Resident #1 "tried to touch" him/her on the leg. LPN #3 documented she notified the Director of Nursing (DON), who informed her to interview Resident #3, which she did. Continued review revealed LPN #3 noted Resident #3 told her "the big" man/woman "touched" him/her two (2) times, by putting his/her hand under Resident #3's clothes, and reached "more than halfway above" his/her knees on the inner thigh. In addition, Resident #3 reported he/she was afraid of Resident #1, and</p>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.</p> <p>5. Date of Compliance:</p>	7/7/14	

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F 225	Continued From page 25 the "last time" Resident #1 touched him/her was on 04/26/14. Further review of the facility's investigation of the incident reported on 04/27/14, revealed no documented evidence cognitively-impaired residents, i.e. those resident with a BIMS score of less than eight (8), were questioned or physically assessed for signs of possible abuse by the alleged perpetrator, Resident #1. Continued review revealed Resident #3 was not assessed for any evidence of sexual assault or other injury after reporting the incident on 04/27/14. Interview with LPN #3 on 05/25/14 at 4:55 PM, revealed she was the House Supervisor on 04/27/14. LPN #3 stated a head to toe physical assessment was not completed on Resident #3 after she learned of the reported incident. Interview with Registered Nurse (RN) #2 on 05/27/14 at 10:00 AM, revealed she was the Charge Nurse on 04/27/14 when Resident #3 reported the incident. She stated she did not perform a head to toe skin assessment on Resident #3 after his/her report because the resident appeared to be okay. Review of Resident #1's Comprehensive Care Plan revealed an intervention was added on 04/28/14 for Resident #1 to be checked by staff every fifteen (15) minutes. However, interviews with Certified Nursing Assistant (CNA) #1 on 05/23/14 at 2:30 PM; CNA #2 on 05/23/14 at 2:50 PM; CNA #3 on 05/29/14 at 4:45 PM; and with CNA #4 on 05/29/14 at 7:15 PM, revealed they were unaware Resident #1 was placed on every fifteen (15) minute checks.	F 225			

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In addition, interviews with LPN #2, on 05/29/14 at 4:00 PM; RN #2, on 05/27/14 at 10:00 AM; and, with LPN #3 on 05/25/14 at 4:55 PM, all revealed they were not aware Resident #1 had been placed on 15 minute checks.

Review of the facility's documentation of the fifteen (15) minute checks for Resident #1, for the period of 04/28/14 through 05/10/14, revealed some of the check sheets were undated and there was inconsistent documentation of the checks.

Interview with the Director of Nursing (DON) on 5/22/14 at 3:00 PM, revealed she was uncertain if she had told the House Supervisor (HS), LPN #3 to start fifteen (15) minute checks on Resident #1 on 04/27/14, after the HS called her at home to report the incident involving Resident #3. She also stated she was uncertain when Resident #1 was put on the fifteen (15) minute checks. The DON indicated she did not know why the records for the fifteen (15) checks were so inconsistent and not dated. She commented there were periods of time when there was no documentation of the checks. The DON stated "if it was not documented it was not done".

Review of the facility's Fax/Incident Report dated 05/10/14, which was sent to the State Survey Agency revealed on 05/10/14 at 1:30 PM a staff member observed Resident #1 with his/her hand between Resident #2's legs while both were sitting in the hallway.

Interview, on 05/24/14 at 4:30 PM, with RN #2 revealed on 05/10/14 the Housekeeping Manager (HM) reported to her Resident #1 was "groping"

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Resident #2 in the "vagina area". Continued interview with RN #2 on 05/27/14 at 10:00 AM, revealed she was the Charge Nurse on 05/10/14 when Resident #1 was observed by the staff member with his/her hand between Resident #2's legs. She stated she did not perform a head to toe skin assessment on Resident #2. She further stated the resident seemed to be okay.

Further interview with the DON, on 05/29/14 at 5:35 PM, revealed the nurses on the units were responsible for ensuring the fifteen (15) minute checks were done. She stated the direction for the checks should have been passed from shift to shift during report. Continued interview revealed she could not understand how any of the nurses could not have known about the checks.

Subsequent interview with the DON, on 5/29/14 at 7:25 PM, revealed interventions should have been put in place to protect Resident #2 and Resident #3, and to observe how they were coping after the incidents involving Resident #1. The DON revealed head to toe physical assessments were not done on Resident #2 and Resident #3 immediately after the incidents; however, she stated they should have been.

Interview with the Administrator on 05/29/14 at 7:30 PM, revealed he knew the fifteen (15) minute checks were implemented, but was unaware the checks were not being done consistently. Continued interview with the Administrator revealed everything had been done to protect the residents.

The facility provided an acceptable credible AOC on 06/05/14 that alleged removal of the IJ effective 06/04/14. Review of the AOC revealed

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F 225	Continued From page 28 the facility implemented the following: 1. The Administrator, DON, ADON and SDN were educated on 05/30/14 by the Regional Director of Operations for Preferred Care Partners, Management Group on Accidents and Supervision on residents must be free from abuse and neglect in order to ensure residents' were protected. 2. The Quality Assurance (QA) Committee reviewed all educational materials and developed a data collection tool on 05/30/14 to validate assessments and Care Plans were being utilized per policy protocol. The tool includes a monitor for aggressive resident behaviors. If aggressive behavior occurs, interventions implemented will be reviewed for effectiveness and a determination if additional interventions are needed will be made. The tool was implemented on 05/30/14 and is ongoing. 3. Resident #3 had a weekly skin assessment completed on 05/03/14, and Resident #2 had a weekly skin assessments completed on 05/16/14. All residents were assessed for the potential to be an abuser, assessments were completed by 06/03/14. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Staff Development Nurse (SDN), and/or the Registered Nurse (RN) Supervisor completed the assessments. Information obtained was used to develop and implement appropriate interventions, and the Care Plans were updated initially by the DON, ADON or the SDN, and will be updated thereafter by RN Unit Managers and Charge Nurses. 4. For any resident to resident allegations, the	F 225			

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F 225	Continued From page 29 aggressor is to be removed from the situation and placed on continuous observation until otherwise notified by the DON and/or the Administrator. CNAs will be notified of the continuous observation order via the CNA Care Plan and "Accunurse" (the CNA computer documentation system). Nurses and CNAs were educated on the process by the DON, ADON or SDN, with the education completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. The facility does not use agency staff. 5. The Administrator and the DON educated the ADON, SDN, RN Unit Managers, Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist tool, with the education completed by 06/03/14. The Administrator and the DON will monitor use of the checklist for every abuse investigation. The facility's general orientation for new hires was revised to include the education. 6. Licensed nursing staff were educated on performing assessments, interventions and updating the Care Plan, implementation and use of the Care Plan, the components of accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. The education was provided by the DON, ADON and SDN, and completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. 7. All facility staff were educated on identifying and reporting abuse, with a focus on resident to resident sexual aggression, and on resident rights. The education was provided by the DON, ADON and SDN, and was completed by	F 225			

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F 225	Continued From page 30 06/03/14. The facility's general orientation for new hires was revised to include the education. 8. The Administrator or the DON will notify the Office of Inspector General, Adult Protective Services, the Ombudsman, and local law enforcement of all sexually aggressive behaviors as required by law and within specified time limits. 9. Educational records will be maintained and will include signatures of attendance, signatures of the education received, and copies of tests designed to determine the effectiveness of the education initiated on 05/30/14 and completed by 06/03/14. 10. The Administrator is charged to administer the facility in a safe and efficient manner to assure the safety of the residents at all times. The Administrator, in conjunction with the DON, ADON and SDN, will assure education is provided and resident care and treatment is delivered in accordance with the Care Plan. Continued evaluation, assessment and Care Plan updates will be used to ensure all residents are safe from harm. 11. Monitoring and utilizing the (QA) Committee data collection tool developed on 05/30/14, is done by the DON, ADON, SDN, RN Unit Managers and RN Supervisors. QA meetings to review the collected data will be held five (5) days per week, and as needed, for thirty (30) days, then weekly for thirty (30) days, then monthly or as needed thereafter. Any identified concerns will be corrected immediately. The State Agency validated the implementation of the facility's AOC as follows:	F 225			

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F 225	Continued From page 31 1. Review of the education sign-in sheets revealed the Administrator, DON, ADON and SDN were educated by the Regional Director of Operations on 05/30/14, prior to the administrative team conducting education of all facility staff. Continued review revealed topics covered included supervision of incidents/accidents; abuse reporting; conducting investigations, and reviewing residents who are at risk or cognitively impaired. Interview with the Administrator, on 06/06/14 at 1:30 PM, revealed the Regional Director of Operations performed the education for the DON, ADON, SDN and himself on 05/30/14. The Administrator stated the education was to ensure all residents were free from abuse and the facility was administered in a manner to assist residents to achieve their highest physical, mental and psychosocial well-being. 2. Review of the data collection tool developed by the QA Committee revealed it included, but was not limited to, validation of assessments completed, use of Care Plans, and a monitor of resident behaviors. In addition, in the case of aggressive behaviors, the tool allowed for a review of current interventions for effectiveness and a determination of the need for additional interventions. Interview with the DON and the Administrator, on 06/05/14 at 4:45 PM, revealed the tool was developed and implemented on 05/30/14, and was being used as outlined in the AOC ongoing. 3. Review of Resident #3's record revealed a weekly skin assessment was completed on	F 225			

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F 225	<p>Continued From page 32</p> <p>05/03/14, with no documented evidence of physical injury. Review of Resident #2's record revealed a weekly skin assessment was completed on 05/16/14, with no documented evidence of physical injury.</p> <p>Review of the facility's implementation documentation binder for the AOC revealed all residents were assessed, care plans were reviewed and updated for residents with identified behaviors, as alleged by the DON, ADON, SDN and RN Supervisor.</p> <p>Interview with the DON, on 06/05/14 at 2:20 PM, revealed she reviewed Resident #3's weekly skin assessment dated 05/03/14, and Resident #2's weekly skin assessment dated 05/16/14 and confirmed the residents had no physical injuries documented on those dates. The DON stated all residents in the facility were assessed, and those with behaviors were monitored for the potential to be an abuser, care planned for the behaviors, and any behaviors were documented every shift. In addition, all new admissions were assessed for any history of behaviors and care planned accordingly.</p> <p>4. Review of the facility's implementation documentation binder for the AOC revealed staff signatures of nurses and CNAs who received the education on residents on continuous supervision, updating and following residents' care plans, use of the Abuse Allegation Checklist and completed post-tests successfully. Continued review revealed all education was provided on or prior to 06/03/14 as alleged.</p> <p>Review of the Abuse Allegation Checklist form utilized by the facility revealed it included</p>	F 225			

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F 225	<p>Continued From page 33</p> <p>removing the aggressor resident and placing the resident on continuous observation. Review of the QA Data Collection tool revealed monitoring included whether staff used the Abuse Allegation Checklist after each incident.</p> <p>Review of the ongoing investigation file for the only resident to resident incident after implementation of the AOC revealed the Abuse Allegation Checklist was used, the aggressor resident was removed from the situation, and 1:1 supervision was initiated and thoroughly documented on. Review of the CNA Worksheet/Care Plan for the resident aggressor revealed it was updated to reflect the increased supervision.</p> <p>Interviews 06/05/14 with CNA #6 at 2:45 PM; CNA #7 at 3:40 PM; and CNA #8 at 3:45 PM, revealed the CNAs education on residents on continuous supervision would be in the "Accunurse" computer system and on the CNA Worksheet/Care Plan. The CNAs reported receiving education related to providing the one on one (1:1) supervision and ensuring they documented the continuous supervision.</p> <p>Interviews 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and, LPN #9 at 3:35 PM, revealed the nurses were educated on use of the Abuse Allegation Checklist, and updating and ensuring the CNAs and they followed residents' care plans.</p> <p>5. Review of the facility's implementation documentation binder for the AOC revealed education sign-in sheets and post-tests for the ADON, SDN, RN Unit Managers, RN Shift</p>	F 225		

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F 225	<p>Continued From page 34</p> <p>Supervisors and Weekend Supervisors who attended the education provided by the Administrator and DON.</p> <p>Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they educated the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist, on or before 06/03/14. The Administrator and DON stated they were monitoring for use of the Checklist with every abuse investigation. They reported the education had been added to the facility's general orientation for new hires.</p> <p>Interview with RN Supervisor #1, on 06/05/14 at 3:15 PM, revealed she had received the education provided, took a post-test and was knowledgeable about when and how to use the Abuse Investigation Checklist.</p> <p>6. Review of the facility's implementation documentation binder for the AOC revealed licensed nursing staff received mandatory education related to performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. Review of the Sign-in sheets reflected the nurses' attendance, and their completion of the post-tests which cross-matched with the signatures. Continued review revealed all education was received on or prior to 06/03/14 by the DON, ADON and SDN.</p> <p>Interviews on 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and LPN #9 at</p>	F 225			

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F 225	<p>Continued From page 35</p> <p>3:35 PM, revealed the nurses confirmed receiving the education on performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents and had taken the post-test afterwards.</p> <p>Interview with the DON on 06/06/14 at 4:45 PM, revealed the education had been provided prior to 06/03/14 as per the AOC for all licensed nursing staff. The DON stated the education had been added to the facility's general orientation for new hires.</p> <p>7. Review of the facility's implementation documentation binder for the AOC revealed all facility staff had received education on abuse which included identifying and reporting abuse, resident to resident sexual aggression and Resident Rights. Continued review of the binder revealed a master list of employees, education sign-in sheets and post-tests which were cross-referenced to confirm the education.</p> <p>Interview with the SDN on 06/05/14 at 4:30 PM, revealed she had participated in providing education for all facility staff related to abuse and Resident Rights. She stated each Department Head had a list of all staff who still needed to receive the education prior to returning to work and ensured the education was provided before the employee was allowed to work.</p> <p>Interview with the DON, on 06/06/14 at 4:45 PM, revealed the facility ensured all facility staff received the mandatory education on abuse and Resident Rights, as per the AOC, by maintaining a master list of all staff and checking off names</p>	F 225			

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F 225	Continued From page 36 as they received the education. She stated a list of all staff on vacation or other leave included their return to work date, and no staff were allowed to be on duty prior to the education being completed. Interviews on 06/05/14 with: Dietary Personnel #1 at 2:00 PM, Dietary Personnel #2 at 2:05 PM; Maintenance Assistant #1 at 2:15 PM; Social Services (SS) Assistant #1 at 2:18 PM; Laundry Personnel #1 at 2:20 PM; Occupational Therapist (OT) #1 at 2:23 PM; LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; CNA #6 at 2:45 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; LPN #9 at 3:35 PM; CNA #7 at 3:40 PM; and, CNA #8 at 3:45 PM revealed they all had attended the mandatory inservices related to abuse and Resident Rights. Those interviewed were able to explain their responsibilities if abuse were observed, reported or suspected. All interviewees were cross-checked to the education sign-in sheets and post-tests. 8. Review of the facility's implementation documentation binder for the AOC revealed an ongoing investigation of a resident to resident altercation, which was not sexual in nature. Review of the investigation documentation revealed all required notifications were made timely in accordance with facility policy and federal and state regulations. Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they would ensure notification of the State Survey Agency, Adult Protective Services, the Ombudsman and local law enforcement of all sexually aggressive behaviors as indicated in the AOC. However,	F 225			

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F 225 Continued From page 37
they reported no incidents of sexually aggressive behaviors had occurred since the alleged date of compliance, 06/04/14.

9. Review of the facility's implementation documentation binder for the AOC revealed education records included sign-in sheets for all education provided. Continued review revealed staff members were checked off from a master list of all employees in order for the facility to ensure every staff member received the education prior to returning to work. In addition, copies of completed post-tests were available for review and were cross-checked with the sign-in sheets. A review of educational offering agendas revealed all topics included in the AOC were provided. Further review revealed all education was completed prior to or on 06/03/14 as alleged.

Interview with the Administrator and the DON on 06/05/14 at 4:45 PM, revealed all the education was mandatory with records being maintained. Interview with the SDN, on 06/05/14 at 4:30 PM, revealed she tracked employee attendance via the sign-in sheets and the master list. She stated she tried to make the inservices interesting to maintain the learners' attention, and utilized post-tests to verify effectiveness of the education.

10. Interview with the Administrator and the DON on 06/06/14 at 1:30 PM, revealed the Administrator was responsible for the overall administration of the facility. He stated his goal was to ensure every resident was safe and staff were knowledgeable regarding providing care according to the written Care Plan. He further stated he had been closely involved with the DON throughout the development and implementation of the AOC, including the monitoring of data

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F 225	Continued From page 38 collected as part of the QA process. The Administrator stated he and the DON ensured the education was provided. He indicated the facility would continue to evaluate, assess and update residents' Care Plans to ensure all residents were safe from harm. Both the Administrator and the DON stated every action outlined in the AOC had been conducted as alleged. 11. Review of the facility's implementation documentation binder for the AOC revealed residents' behaviors were documented by staff every shift. Continued review revealed QA team members reviewed the collected data daily Monday through Friday. Interview with the DON revealed she reviewed all documented behaviors daily Monday through Friday to ensure the Care Plans were revised to include new interventions as indicated by the exhibited behavior. She stated the data is collected by her, the ADON, SDN, RN Unit Managers and RN Supervisors, with all behaviors reviewed by her.	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 review of the facility's policies, it was determined the facility	F 226		

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F 226	Continued From page 39 failed to have an effective system in place to ensure the facility's policy and procedures related to abuse were implemented. In addition, the facility's policy failed to provide guidance to conduct a thorough investigation. This failure affected two (2) of ten (10) sampled residents (Resident #3 and #2). On 04/27/14, Resident #3 reported being touched on the inner thigh under his/her clothes by Resident #1. Resident #3 reported the incident occurred on 04/26/14. The facility initiated their investigation of the incident immediately; however, their actions did not include a physical assessment of Resident #3 for possible injury. Although cognitively intact residents on the unit were interviewed by the facility, non-interviewable residents were not assessed for signs of possible abuse. In addition, the facility revised Resident #1's plan of care to implement visual checks of the resident every fifteen (15) minutes; however, review of documentation and interviews with staff revealed the checks were not conducted consistently. As a result of the facility's failure to monitor Resident #1, other residents were not protected from potential abuse. On 05/10/14, a staff member observed Resident #1 to have his/her hand between Resident #2's legs. Resident #1 was placed on 1:1 supervision at that time, until transferred to the hospital for further evaluation. The resident was discharged from the facility prior to initiation of the survey, and was not available for observation or interview. (Refer to F-223, F-225 and F-282) The facility's failure to have an effective system in place to ensure implementation of Abuse Policies to prevent abuse was likely to cause risk for serious injury, harm, impairment or death.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
		F226	<ol style="list-style-type: none"> All residents are at risk for abuse due to physical dependency, decreased cognition, and decreased mobility. All residents were evaluated for the potential to abuse upon admission and with significant change in behavior by the admitting LPN/RN and Unit Manager. Information from the evaluation determines if additional assessment and interventions would be necessary for each resident in the center. Appropriate interventions will be implemented and Care Plans updated by 7/3/14 initially by DON, Assistant Director of Nursing, Staff Development RN and thereafter RN Unit Managers and Charge Nurse. An Abuse Investigation Checklist was developed by QA Committee on 5/30/14 to be used when allegations of abuse occur. Facility abuse policy was updated in May 2014 to include the use of the Abuse Investigation Checklist. Staff responsible for the use of this checklist include the Unit Manager, 		

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F 226	Continued From page 40 Immediate Jeopardy (IJ) was identified on 05/28/14 and determined to exist on 04/27/14. The facility was notified of the Immediate Jeopardy on 05/28/14. The facility provided an acceptable credible Allegation of Compliance (AOC) on 06/05/14 with the facility alleging removal of the IJ on 06/04/14. The IJ was verified to be removed on 06/04/14 as alleged, prior to exit from the facility on 06/06/14, with remaining non-compliance at 42 CFR 483.13, Resident Behavior and Facility Practice, F-226 with a Scope and Severity of "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor the Abuse Policies for implementation to ensure residents are free from abuse. The findings include: Review of the facility's policy titled, "Abuse: Resident to Resident", effective October 2012, revealed immediate action was to be taken in incidents of resident to resident altercations to prevent reoccurrence of altercations. Monitoring of residents at the nurse's station, 1:1 therapy/activity and discharge to the hospital for medical evaluation were some measures staff could use to keep aggressive residents separated. Further review of the policy revealed an investigation was to be completed and documentation was to include interventions placed to prevent reoccurrence's. Further review of the policy revealed it did not address specific measures to ensure a thorough investigation was conducted, e.g. conducting physical assessments of victim residents or other vulnerable non-interviewable residents.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Supervisor, Administrative RN's or Administrator. Administrator and DON educated the Assistant Director of Nursing, Staff Development RN, RN Unit Manager, Shift Supervisors, and Weekend Supervisor as to the purpose of the Abuse Investigation Checklist and use of this tool with completion by 7/3/14. Administrator and DON monitor use of checklist with every abuse investigation as needed. Licensed Nursing staff to be in-serviced on components of accurate and thorough shift reporting. Education was conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. Licensed Nursing staff to be in-serviced on identification, documentation, and interventions related to abuse allegations. Education was completed by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. All staff will be in-serviced on abuse.		

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F 226	Continued From page 41 Review of the facility's Incident Report Form dated 04/27/14, revealed the facility reported Resident #1 touched Resident #3 on the thigh under his/her clothes on 04/26/14. Continued review revealed Resident #3 expressed he/she was afraid of Resident #1. Review of the facility's investigation of the incident reported on 04/27/14, revealed no documented evidence cognitively-impaired residents, i.e. those resident with a BIMS score of less than eight (8), were interviewed or assessed for signs of possible abuse by the alleged perpetrator, Resident #1. Continued review revealed Resident #3 was not assessed for injury on 04/27/14 after the incident was reported. Interview with LPN #3 on 05/25/14 at 4:55 PM, who was the House Supervisor on 04/27/14, and on 05/27/14 at 10:00 AM with Registered Nurse (RN) #2, who was the Charge Nurse, revealed neither nurse conducted a head to toe physical assessment on Resident #3 to determine if the resident had sustained any injury. RN #2 stated the resident appeared to be okay. Review of the facility's five (5) Day Follow-up Report dated 05/01/14, for the 04/27/14 incident, revealed Resident #1 was to remain "under close watch by staff during the investigation". However, review of the medical record for Resident #1 revealed no documented evidence Resident #1 remained under close watch of staff as indicated in the investigation; was monitored at the nurse's station; or provided 1:1 therapy/activity as indicated per facility policy.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> what it is, and the reporting, with a focus on resident to resident sexual aggressiveness. Education will be conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. All staff was in-serviced on Resident Rights. Education will be conducted by DON, Assistant Director of Nursing, and Staff Development RN with a completion date of 7/3/14. No agency in use at the facility. All new hires will be educated during general orientation by the Staff Development RN. QA Committee members will review minimally 5 days a week for 30 days or additionally as necessary until 7/21/14, then one time weekly until 8/21/14 or as needed, then monthly thereafter or as needed sooner. 4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/06/2014
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NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018
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Review of Resident #1's Comprehensive Care Plan revealed on 04/28/14, an intervention for Resident #1 to be monitored every fifteen (15) minute checks was added.

However, review of the documentation of the fifteen (15) minute checks for Resident #1 between 04/28/14 and 05/10/14, revealed some checks with no dates and inconsistent documentation. Further review of the fifteen (15) minute check documentation revealed no checks were documented on several days during that time frame.

Interview on 04/27/14 at 10:00 AM, with RN #2, revealed she did not think Resident #1 was put on every fifteen (15) minute checks after the incident. RN #2 stated staff kept "an eye on" Resident #1; however, indicated she did not implement special monitoring of the resident on 04/27/14 per the facility's policy.

Interviews with Certified Nursing Assistant (CNA) #2 on 05/23/14 at 2:50 PM; with CNA #3 on 05/29/14 at 4:45 PM; and, with CNA #4 on 05/29/14 at 7:15 PM revealed they had been told by other CNAs to "keep an eye on" Resident #1; however, they were not aware of when Resident #1 was placed on every fifteen (15) minute checks.

Review of the facility's Incident Report Form dated 05/10/14, revealed Resident #1 was observed with his/her hand between Resident #2's legs by a staff person.

Interview, on 05/24/14 at 4:30 PM, with RN #2 revealed on 05/10/14 the staff reported to her Resident #1 was "groping" Resident #2 in the

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*This Plan of Correction is the center's credible allegation of compliance.
Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

Medical Director Quarterly. Next meeting with Medical Director will be held in July. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director. Monitoring of the use of the checklist will be completed by the DON and/or Administrator throughout the investigation and reporting abuse cycle. Information reviewed will include documentation, care plan use, and any additional interventions put in place related to the abuse allegation and will be completed by the DON with each investigation.

5. Date of Compliance:

7/7/14

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F 226	<p>Continued From page 43</p> <p>"vagina area". Per interview, RN #2 did not assess Resident #2 for injury because the resident appeared to be okay.</p> <p>Interview with the Director of Nursing (DON) on 5/22/14 at 3:00 PM, revealed she did not know why the fifteen (15) minute check documentation was undated, inconsistent or why there was no documentation of the checks for several days. Additional interview with the DON, on 05/29/14 at 5:35 PM, revealed the Abuse Policy was not followed as a result of not ensuring the documenting of the fifteen minutes checks, which was an intervention placed to prevent reoccurrence's. In addition, the DON revealed head to toe physical assessments on Resident #2 and Resident #3 should have been completed immediately after the incidents; however, staff failed to do so.</p> <p>The facility provided an acceptable credible AOC on 06/05/14 that alleged removal of the IJ effective 06/04/14. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. The Administrator, DON, ADON and SDN were educated on 05/30/14 by the Regional Director of Operations for Preferred Care Partners, Management Group on Accidents and Supervision on residents must be free from abuse and neglect in order to ensure residents' were protected. 2. The Quality Assurance (QA) Committee reviewed all educational materials and developed a data collection tool on 05/30/14 to validate assessments and Care Plans were being utilized per policy protocol. The tool includes a monitor for aggressive resident behaviors. If aggressive 	F 226			

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F 226	Continued From page 44 behavior occurs, interventions implemented will be reviewed for effectiveness and a determination if additional interventions are needed will be made. The tool was implemented on 05/30/14 and is ongoing. 3. Resident #3 had a weekly skin assessment completed on 05/03/14, and Resident #2 had a weekly skin assessments completed on 05/16/14. All residents were assessed for the potential to be an abuser, assessments were completed by 06/03/14. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Staff Development Nurse (SDN), and/or the Registered Nurse (RN) Supervisor completed the assessments. Information obtained was used to develop and implement appropriate interventions, and the Care Plans were updated initially by the DON, ADON or the SDN, and will be updated thereafter by RN Unit Managers and Charge Nurses. 4. For any resident to resident allegations, the aggressor is to be removed from the situation and placed on continuous observation until otherwise notified by the DON and/or the Administrator. CNAs will be notified of the continuous observation order via the CNA Care Plan and "Accunurse" (the CNA computer documentation system). Nurses and CNAs were educated on the process by the DON, ADON or SDN, with the education completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. The facility does not use agency staff. 5. The Administrator and the DON educated the ADON, SDN, RN Unit Managers, Shift Supervisors and Weekend Supervisors on the	F 226			

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F 226	Continued From page 45 use of the Abuse Investigation Checklist tool, with the education completed by 06/03/14. The Administrator and the DON will monitor use of the checklist for every abuse investigation. The facility's general orientation for new hires was revised to include the education. 6. Licensed nursing staff were educated on performing assessments, interventions and updating the Care Plan, implementation and use of the Care Plan, the components of accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. The education was provided by the DON, ADON and SDN, and completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. 7. All facility staff were educated on identifying and reporting abuse, with a focus on resident to resident sexual aggression, and on resident rights. The education was provided by the DON, ADON and SDN, and was completed by 06/03/14. The facility's general orientation for new hires was revised to include the education. 8. The Administrator or the DON will notify the Office of Inspector General, Adult Protective Services, the Ombudsman, and local law enforcement of all sexually aggressive behaviors as required by law and within specified time limits. 9. Educational records will be maintained and will include signatures of attendance, signatures of the education received, and copies of tests designed to determine the effectiveness of the education initiated on 05/30/14 and completed by 06/03/14.	F 226			

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10. The Administrator is charged to administer the facility in a safe and efficient manner to assure the safety of the residents at all times. The Administrator, in conjunction with the DON, ADON and SDN, will assure education is provided and resident care and treatment is delivered in accordance with the Care Plan. Continued evaluation, assessment and Care Plan updates will be used to ensure all residents are safe from harm.

11. Monitoring and utilizing the (QA) Committee data collection tool developed on 05/30/14, is done by the DON, ADON, SDN, RN Unit Managers and RN Supervisors. QA meetings to review the collected data will be held five (5) days per week, and as needed, for thirty (30) days, then weekly for thirty (30) days, then monthly or as needed thereafter. Any identified concerns will be corrected immediately.

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

1. Review of the education sign-in sheets revealed the Administrator, DON, ADON and SDN were educated by the Regional Director of Operations on 05/30/14, prior to the administrative team conducting education of all facility staff. Continued review revealed topics covered included supervision of incidents/accidents; abuse reporting; conducting investigations, and reviewing residents who are at risk or cognitively impaired.

Interview with the Administrator, on 06/06/14 at 1:30 PM, revealed the Regional Director of Operations performed the education for the DON, ADON, SDN and himself on 05/30/14. The

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F 226	<p>Continued From page 47</p> <p>Administrator stated the education was to ensure all residents were free from abuse and the facility was administered in a manner to assist residents to achieve their highest physical, mental and psychosocial well-being.</p> <p>2. Review of the data collection tool developed by the QA Committee revealed it included, but was not limited to, validation of assessments completed, use of Care Plans, and a monitor of resident behaviors. In addition, in the case of aggressive behaviors, the tool allowed for a review of current interventions for effectiveness and a determination of the need for additional interventions.</p> <p>Interview with the DON and the Administrator, on 06/05/14 at 4:45 PM, revealed the tool was developed and implemented on 05/30/14, and was being used as outlined in the AOC ongoing.</p> <p>3. Review of Resident #3's record revealed a weekly skin assessment was completed on 05/03/14, with no documented evidence of physical injury. Review of Resident #2's record revealed a weekly skin assessment was completed on 05/16/14, with no documented evidence of physical injury.</p> <p>Review of the facility's implementation documentation binder for the AOC revealed all residents were assessed, care plans were reviewed and updated for residents with identified behaviors, as alleged by the DON, ADON, SDN and RN Supervisor.</p> <p>Interview with the DON, on 06/05/14 at 2:20 PM, revealed she reviewed Resident #3's weekly skin assessment dated 05/03/14, and Resident #2's</p>	F 226			

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weekly skin assessment dated 05/16/14 and confirmed the residents had no physical injuries documented on those dates. The DON stated all residents in the facility were assessed, and those with behaviors were monitored for the potential to be an abuser, care planned for the behaviors, and any behaviors were documented every shift. In addition, all new admissions were assessed for any history of behaviors and care planned accordingly.

4. Review of the facility's implementation documentation binder for the AOC revealed staff signatures of nurses and CNAs who received the education on residents on continuous supervision, updating and following residents' care plans, use of the Abuse Allegation Checklist and completed post-tests successfully. Continued review revealed all education was provided on or prior to 06/03/14 as alleged.

Review of the Abuse Allegation Checklist form utilized by the facility revealed it included removing the aggressor resident and placing the resident on continuous observation. Review of the QA Data Collection tool revealed monitoring included whether staff used the Abuse Allegation Checklist after each incident.

Review of the ongoing investigation file for the only resident to resident incident after implementation of the AOC revealed the Abuse Allegation Checklist was used, the aggressor resident was removed from the situation, and 1:1 supervision was initiated and thoroughly documented on. Review of the CNA Worksheet/Care Plan for the resident aggressor revealed it was updated to reflect the increased supervision.

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F 226	Continued From page 49 Interviews 06/05/14 with CNA #6 at 2:45 PM; CNA #7 at 3:40 PM; and CNA #8 at 3:45 PM, revealed the CNAs education on residents on continuous supervision would be in the "Accunurse" computer system and on the CNA Worksheet/Care Plan. The CNAs reported receiving education related to providing the one on one (1:1) supervision and ensuring they documented the continuous supervision. Interviews 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and, LPN #9 at 3:35 PM, revealed the nurses were educated on use of the Abuse Allegation Checklist, and updating and ensuring the CNAs and they followed residents' care plans. 5. Review of the facility's implementation documentation binder for the AOC revealed education sign-in sheets and post-tests for the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors who attended the education provided by the Administrator and DON. Interview with the Administrator and the DON, on 06/06/14 at 1:30 PM, revealed they educated the ADON, SDN, RN Unit Managers, RN Shift Supervisors and Weekend Supervisors on the use of the Abuse Investigation Checklist, on or before 06/03/14. The Administrator and DON stated they were monitoring for use of the Checklist with every abuse investigation. They reported the education had been added to the facility's general orientation for new hires. Interview with RN Supervisor #1, on 06/05/14 at	F 226			

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F 226	<p>Continued From page 50</p> <p>3:15 PM, revealed she had received the education provided, took a post-test and was knowledgeable about when and how to use the Abuse Investigation Checklist.</p> <p>6. Review of the facility's implementation documentation binder for the AOC revealed licensed nursing staff received mandatory education related to performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents. Review of the Sign-in sheets reflected the nurses' attendance, and their completion of the post-tests which cross-matched with the signatures. Continued review revealed all education was received on or prior to 06/03/14 by the DON, ADON and SDN.</p> <p>Interviews on 06/05/14 with LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; and LPN #9 at 3:35 PM, revealed the nurses confirmed receiving the education on performing assessments, interventions and updating the Care Plan, implementation of the Care Plan, accurate and thorough shift reporting, and identification, documentation and investigation of incidents and accidents and had taken the post-test afterwards.</p> <p>Interview with the DON on 06/06/14 at 4:45 PM, revealed the education had been provided prior to 06/03/14 as per the AOC for all licensed nursing staff. The DON stated the education had been added to the facility's general orientation for new hires.</p> <p>7. Review of the facility's implementation</p>	F 226			

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F 226	Continued From page 51 documentation binder for the AOC revealed all facility staff had received education on abuse which included identifying and reporting abuse, resident to resident sexual aggression and Resident Rights. Continued review of the binder revealed a master list of employees, education sign-in sheets and post-tests which were cross-referenced to confirm the education. Interview with the SDN on 06/05/14 at 4:30 PM, revealed she had participated in providing education for all facility staff related to abuse and Resident Rights. She stated each Department Head had a list of all staff who still needed to receive the education prior to returning to work and ensured the education was provided before the employee was allowed to work. Interview with the DON, on 06/06/14 at 4:45 PM, revealed the facility ensured all facility staff received the mandatory education on abuse and Resident Rights, as per the AOC, by maintaining a master list of all staff and checking off names as they received the education. She stated a list of all staff on vacation or other leave included their return to work date, and no staff were allowed to be on duty prior to the education being completed. Interviews on 06/05/14 with: Dietary Personnel #1 at 2:00 PM; Dietary Personnel #2 at 2:05 PM; Maintenance Assistant #1 at 2:15 PM; Social Services (SS) Assistant #1 at 2:18 PM; Laundry Personnel #1 at 2:20 PM; Occupational Therapist (OT) #1 at 2:23 PM; LPN #4 at 2:30 PM; LPN #5 at 2:35 PM; CNA #6 at 2:45 PM; RN Supervisor #1 at 3:15 PM; LPN #7 at 3:20 PM; LPN #8 at 3:25 PM; LPN #6 at 3:30 PM; LPN #9 at 3:35 PM; CNA #7 at 3:40 PM; and, CNA #8 at 3:45 PM	F 226			