

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

AMENDED

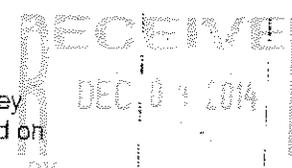
An Abbreviated/Partial Extended Survey investigating KY00022110 was initiated on 08/19/14 and concluded on 09/11/14. KY00022110 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 08/29/14 and was determined to exist on 07/26/14 in the areas of 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225, and F-226; 42 CFR 483.20 Resident Assessment, F-280 and F-282; 42 CFR 483.75 Administration, F-490 and F-514 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, F-223, F-225 and F-226. The facility was notified of the Immediate Jeopardy on 08/29/14.

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. The facility assessed Resident #2 to be cognitively intact at the end of June 2014, and on 07/26/14 at approximately 4:30 PM, State Registered Nursing Assistant (SRNA) #1 reported to Licensed Practical Nurse (LPN) #1/Charge Nurse a visitor had tapped her on the arm and said, "you need to do something about this". SRNA #1 observed Resident #1 and Resident #2 in the hallway where Resident #2 had his/her hand in the waist band of Resident #1's pants. Interviews with staff revealed Resident #2 continued to seek out Resident #1 on other occasions and was found with his/her hands touching Resident #1 inappropriately

F 000

Maysville Nursing and Rehabilitation Facility does not believe, nor does the facility admit that any deficiencies exist.

Maysville Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Maysville Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileges which



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

Cathy Bruch

TITLE

Administrator

(X8) DATE

12/4/14

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014	
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 000 Continued From page 1
again; however, there was no documented evidence the facility implemented facility policies or interventions to protect Resident #1 from further alleged abuse by Resident #2. Staff interviews revealed there were at least four (4) alleged incidents of abuse by Resident #2 towards Resident #1 which were reported to the Administrator who told staff not to report the alleged abuse to Resident #1's Physician or POA or document the incidents. Resident #2 was sent out to the hospital for a psychiatric (psych) evaluation, returned to the facility and continued to seek out Resident #1. Interview and record review revealed no documented evidence Resident #1's Physician or Power of Attorney (POA)/Legal Representative was immediately notified of the incidents and no documented evidence the facility initiated an investigation into the incidents of alleged abuse and reported the incidents to the appropriate State Agencies. Additionally, staff interviews and record review revealed no documented evidence the facility ensured interventions were implemented for Resident #1 or Resident #2 to prevent further abuse, no documented evidence the facility revised the residents' care plans, and no documented evidence physical assessment of Resident #1 was performed to identify possible physical injuries.

The facility provided an acceptable credible Allegation of Compliance (AOC), related to the Immediate Jeopardy on 09/09/14, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The State Survey Agency validated the Immediate Jeopardy was removed on 09/03/14, as alleged with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.13 Resident Behavior and Facility Practice,

F 000 Maysville Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Maysville Nursing and Rehabilitation Facility offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents.

Maysville Nursing and Rehabilitation Facility strives to provide the highest quality care while ensuring the rights and safety of all residents.

F157
It is and was on the dates of survey the policy of Maysville Nursing and Rehabilitation Facility to notify the resident, resident's physician and, if known, the resident's legal representative of a need to

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>Continued From page 2</p> <p>F-223, F-225, and F-226; 42 CFR 483.20 Resident Assessment, F-280 and F-282; 42 CFR 483.75 Administration, F-490 and F-514 at a Scope and Severity (S/S) of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>F-157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 000	<p>significantly change the resident plan of care.</p> <ol style="list-style-type: none"> On 08-30-14 at 10:45 A.M. the Vice President of Clinical Services met with Resident #2's Power of Attorney (P.O.A.) to validate she was notified of all allegations of inappropriate behavior and actions taken by the facility. Resident #2's physician was contacted on 08-30-14 at 3:05 P.M. by the Vice President of Clinical Services, who stated he was well aware of the resident's change in behaviors. He stated that he informed surveyors he had been notified and updated concerning both Residents #1 and 	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014	
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 157 Continued From page 3
The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure residents' Physicians and legal representative were immediately notified of an alleged sexual abuse incident for two (2) of eight (8) sampled residents (Residents #1 and #2). (Refer to F-223)

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

F 157
#2. Resident #1's son was contacted on 08-30-14 at 4:00 P.M. by the Vice President of Clinical Services to ensure he was aware of the contact between Resident #2 and Resident #1. He stated he was aware and had been notified by facility staff. No other concerns were noted.
2. All staff (including licensed staff) were in-serviced on 8-29-14 at 10:00 P.M., 08-30-14 at 10:00 A.M., and 08-30-14 at 2:00 P.M. by the Administrator and Director of Nursing (DON). This in-service covered the accuracy of the clinical record, in relation to the documentation and notification of

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 4
Resident #1; however, staff intervened before he/she was able to touch Resident #1. On 08/09/14 at 10:40 AM Resident #2 was found in Resident #1's room again, redirected out of the room; however, continued to return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation.

Furthermore, interviews revealed even though nursing staff observed and reported the above alleged abuse of Resident #1 by Resident #2, they were informed by the Administrator not to document the incidents, or conduct notifications to the Physician or Power of Attorneys (POAs) for Resident #1 and Resident #2.

The facility's failure to ensure an effective system was in place to ensure the Physician and POA, or legal representative, were immediately notified of a potential incident of sexual abuse was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 08/29/14, and determined to exist on 07/26/14. The facility was notified of the Immediate Jeopardy on 08/29/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The Immediate Jeopardy was verified to be removed on 09/03/14 prior to exiting the facility on 09/11/14, with remaining non-compliance at F-157 Notifications of Changes, at a Scope and Severity of "D" while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure Physicians and legal representatives are notified in the event of an incident, accident or changes in the resident's

F 157 physicians and P.O.A. or legal representative.

All female residents were interviewed by the Social Service Director and Activity Director on 8/30/14 as to whether they had been touched inappropriately by a male resident or anyone since residing here. All male residents were questioned by the Director of Nursing (DON) and administrative nurses on 9/2/14 as to whether they had been touched inappropriately by a male resident or anyone since residing here. The answers were unanimously "no." Licensed staff conducts weekly skin assessments on all residents in the facility.

3. A daily monitoring system began on 08-29-14. The Interact II Stop and Watch Program is being used to gather input from

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 : Continued From page 5
condition.

The findings include:

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

Record review revealed Resident #1 was admitted by the facility on 12/12/13, with diagnoses which included Advanced Dementia, Alzheimer's Dementia with Behavior Disturbance, Sundown Syndrome (a syndrome characterized by increased confusion at night), Anxiety and Diabetes.

Record review revealed the facility admitted Resident #2 on 04/12/12 with diagnoses which included Parkinson's Disease, Coronary Artery Disease (CAD), Hypertension and Dementia.

Interview with LPN #1 on 08/22/14 at 1:00 PM, revealed on 07/26/14 "sometime" after 2:00 PM, SRNA #1 reported Resident #2 had his/her hand in the waist band of Resident #1's pants. She stated staff was told on 07/26/14 by the Administrator not to document Resident #2's behaviors, but start every 15 minute checks. She stated neither the POAs for Residents #1 and #2, nor the Physician, were notified.

Interview with the Director of Nursing (DON), on 08/29/14 at 8:00 PM, revealed she reported to the

F 157

all staff. This tool will alert the Administrator, and in her absence, the Director of Nursing of any required notifications. On weekends, the charge nurse will complete this process. The INTERACT quality improvement program is utilized to improve the early identification, evaluation, management, documentation, and communication about acute changes in condition of

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014	
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 157 Continued From page 6

Administrator, on 07/28/14, it was reported to her Resident #2 was in the hallway pulling on Resident #1's shirt. However, interview with LPN #10, on 09/04/14 at 3:10 PM, Resident #2 was found in Resident #1's room with his/her hand up under the resident's shirt. Record review revealed no documented evidence the Physician or the POA for Resident #1 or Resident #2 was notified of the incident.

Review of Resident #1's record revealed no documented evidence of this incident with Resident #2 and no documented evidence the Physician or family were notified.

Interview with SRNA #7, on 09/04/14 at 2:25 PM, revealed on 08/04/14 when Resident #2 returned from a hospitalization, she entered Resident #1's room and observed Resident #2 with his/her hand pushed up under Resident #1's pant leg to the groin area. SRNA #7 further stated she removed Resident #2 from Resident #1's room and reported the incident to Licensed Practical Nurse (LPN) #10.

Interview with SRNA #2, on 09/04/14 at 2:40 PM and on 09/10/14 at 9:25 AM, revealed on 08/04/14 she observed Resident #2's hand more than halfway down inside the front of Resident #1's pants, and she reported it to the nurse.

However, review of Resident #1's clinical record revealed no documented evidence the resident's POA or Physician were notified of the alleged sexual abuse incidents by Resident #2 on 08/04/14 after his/her return to the facility from the hospital. Review of Resident #2's record revealed no documented evidence the POA or Physician were notified of these two incidents on

F 157

residents in our facility. When an acute change in condition occurs, the Stop and Watch Tool can be used by State Registered Nursing Assistants (SRNAs) or other staff to identify changes in residents and clearly communicate those changes to the licensed nursing staff. This written tool is used by staff who has direct contact with residents and is in a position to observe changes, including rehabilitation therapists,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	<p>Continued From page 7 08/04/14.</p> <p>Interview with Resident #1's POA, on 08/22/14 at 12:15 PM, revealed when he was visiting one night, he was told by a nurse that his mother had been approached in the hallway by another resident but nothing happened. He stated the nurse said it was not a sexual thing. He further stated that nurse no longer worked at the facility. Continued interview revealed the POA had not been told anything else by anyone at the facility.</p> <p>Interview with the DON and the Administrator, on 08/29/14 at 3:45 PM, revealed on 07/30/14 Resident #2 continued to seek out Resident #1. Resident #2 was observed in the doorway of Resident #1's room reaching for him/her.</p> <p>Continued interview with the Administrator, on 08/29/14 at 3:45 PM, revealed Resident #2's POA was first notified of the behaviors by the Administrator on 07/30/14. She further stated there was no documented evidence of when the Physician was first notified of the incidents.</p> <p>Interview with Resident #2's POA, on 09/04/14 at 10:20 AM, revealed she could not remember the date she was notified of an incident regarding inappropriate behavior, she thought the Administrator had called on 07/26/14 but maybe it was 07/30/14.</p> <p>Interview with the Attending Physician for Resident #1 and Resident #2, on 08/22/14 at 4:00 PM, revealed he was made aware of Resident #2's sexual behaviors toward Resident #1 on 07/30/14, and he gave an order to send Resident #2 for a Psych evaluation. He stated he was not made aware of the behavior on 08/04/14 upon</p>	F 157	<p>environmental services, and dietary staff. Any employee that notices a change in a resident can obtain a Stop and Watch duplicate form at the nurse's stations. Once a Stop and Watch tool has been initiated by a staff member, one copy is immediately given to the licensed nurse and the other copy is given to the DON for follow up. All staff of the facility was trained when the program was initiated in August 2011 and all new employees are trained during their</p>	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 8

Resident #2's return to the facility, but was notified on 08/09/14 and ordered to send the resident back to the hospital for another psych evaluation.

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

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

F 157

orientation period. All staff will be educated a minimum of twice annually on the SBAR "Stop & Watch" and as needed. The Administrator, DON, ADON and/or department supervisors (housekeeping supervisor, dietary supervisor, medical records supervisor, activity supervisor, MDS Coordinator, SSD, and Maintenance Director) will conduct these trainings for their respective departments as needed. All staff were re-educated

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	<p>Continued From page 9</p> <p>of the clinical record. The Administrator and the DON were able to verbalize understanding of the education.</p> <p>4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30 AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.</p> <p>On 08/29/14 at 10:00 PM, 08/30/14 at 10:00 AM, and 08/30/14 at 2:00 PM, all staff were in-serviced by the Administrator and the DON related to accuracy of the clinical record.</p> <p>On 08/29/14 at 10:00 PM and 10:30 PM, 08/30/14 at 10:00 AM and 10:30 AM and 08/30/14 at 1:00 PM and 2:00 PM, the Administrator and the DON educated all staff on the following: the definitions of abuse; reporting obligations of abuse allegations; identification of abuse; investigation of abuse allegations and implementation of the facility's Resident Protection Policy; accuracy of the clinical record; and revision of care plans. A question and answer period was held at the conclusion of all in-services to establish competency.</p> <p>Twelve (12) employees out of the facility for medical leave, maternity leave or vacation were educated by the DON via telephone. No staff will be permitted to work until they have been educated.</p> <p>5. All resident records were reviewed by the DON, Minimum Data Set (MDS) staff, Admission</p>	F 157	<p>on SBAR and "Stop & Watch" by the Administrator and DON on 8/29/14 and 8/30/14 and instructed that one copy is to be given to the charge nurse and the other copy be given to the DON. Any resident that experiences a change in condition is reviewed for the effective use of the Interact II program including the Stop and Watch tool and the Situation, Background, Assessment, Recommendations (SBAR) form. The SBAR Form/Acute</p>	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 520 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 157 Continued From page 10

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

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

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

F-157

Change in Condition Progress Note is designed to enhance the nursing evaluation of and documentation on residents who have a change in condition and improve communication with primary care providers. It is intended to be used as a change in condition progress note and should replace, rather than add to, other documentation. Competency of all staff will be established through daily reviews of resident status and evidence

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014	
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 157 Continued From page 11

inappropriate behavior and actions taken by the facility.

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

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

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

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

F 157

of the usage of the above mentioned tools (utilization of the Stop & Watch). Daily reviews of resident's status are achieved by review of any change in condition of any resident noted from the nursing communication sheets, acute monitoring log, physician's orders and incident reports, this will ensure that staff have identified the change and react appropriately by completing an SBAR "Stop & Watch" form and proper notifications to

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157

Continued From page 12

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

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

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

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

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

1. Copies of skin assessments, performed by licensed staff, for Resident #1 on 07/28/14 and 08/05/14 were reviewed. No concerns were revealed during this review. A review of the complete assessment by the Physician on 07/31/14 revealed no concerns.

2. A review of every 15 minute checks of Resident #2 by nursing staff, for the period of 07/26/14 through 07/30/14, revealed no concerns. Observation of Resident #2 on 09/04/14 at 10:05 AM, revealed the resident to be sitting in the dining room with a staff member playing cards. Interview with SRNA #6 on 09/04/14 at 10:09 AM, revealed she was assigned to do 1:1 with Resident #2. Interview

F 157

physician and POA. If there are questions related to notification during the daily review, the Administrator will review the clinical record as needed.

4. Members of the facility's Quality Assurance (QA) committee include: Administrator, Assistant Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Social Service Director (SSD), Dietary Supervisor, Housekeeping Supervisor,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157: Continued From page 13

with the Administrator on 09/11/14 at 1:55 PM, confirmed Resident #2 was started on 1:1 monitoring on 08/29/14 and the monitoring was ongoing.

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

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

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

F 157:

Maintenance Supervisor, Activity Director, Director of Financial Services, Minimum Data Set (MDS) Coordinator, Consultant Pharmacist, and Medical Director.

A QA process has been implemented as of 08-29-14 by the Administrator to monitor on a continual basis, the residents' condition through daily morning meetings with the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, administrative nurses,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 157 Continued From page 14

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

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

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

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

F 157

Activity Director,
Social Services
Director,
Housekeeping
Supervisor, Financial
Services Director
charge nurses and
therapy team. The
Administrator, DON,
and/or ADON will
review all incident
reports, nursing report
sheets, acute
monitoring logs, and
physician's orders to
verify appropriate
notification. If there
are questions related to
notification during the
daily review, the
Administrator will
review the clinical
record as needed for
residents with
identified concerns.
The charge nurse will
complete this process

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 157 Continued From page 15

aware of all allegations of inappropriate behavior on the part of Resident #2, and was aware of actions taken by the facility.

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

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

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

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

F 157

on the weekends or in the absence of the Administrator, DON, and/or ADON. This will alert the Administrator of the required physician and P.O.A. or legal representative of notification which need to be made. The Administrator will check records for appropriate notifications. In the absence of the Administrator, the Director of Nursing, Assistant Director of Nursing, or charge nurses will complete this process. The daily morning meetings are conducted Monday through Friday and the audits are completed by the Administrator.

F 223 483.13(b), 483.13(c)(1)(i) FREE FROM
SS=J ABUSE/INVOLUNTARY SECLUSION

F 223

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 223 Continued From page 16

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to protect one (1) of eight (8) sampled residents from abuse (Resident #1). The facility failed to implement policy and procedures to initiate an investigation of alleged abuse and implement interventions to prevent recurrence.

Interviews with nurses and State Registered Nursing Assistants (SRNAs) revealed Resident #2 was observed touching Resident #1 inappropriately on several different occasions. On 07/26/14, a visitor pointed at Resident #1 and Resident #2 and told a SRNA "you need to do something about this", as Resident #2 was observed with his/her hand inside the waist band of Resident #1's pants. On 7/28/14, Resident #2 had his/her hand under Resident's #1's shirt. On 07/30/14 sought out Resident #1, displayed inappropriate behaviors (touching inappropriately), was difficult to redirect, and was sent out to the hospital for a psychiatric (psych) evaluation. On 08/04/14, Resident #2 was readmitted and was observed on two (2) separate occasions that day to have more than half of his/her hand in Resident #1's pants, once near

F 223

In the absence of the Administrator, the DON and/or ADON, or charge nurse will conduct the audits. The charge nurses complete the process on the weekends. The results of the audit from the weekend charge nurses are reviewed by the Administrator, DON or ADON on the following work day. This QA process will be ongoing. The Administrator has the documentation of the completion of the daily audits and the weekend audit documentation from charge nurses is forwarded to the Administrator for review. In addition,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	<p>Continued From page 17.</p> <p>Resident #1's pubic area down the front of the resident's pants and the other time in the groin area up the resident's pant's leg. In addition, staff interviews revealed Resident #2 tried unsuccessfully on other occasions to seek out Resident #1; however, staff intervened before he/she was able to touch Resident #1. On 08/09/14 at 10:40 AM Resident #2 was found in Resident #1's room again, redirected out of the room; however, continued to return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation.</p> <p>Furthermore, interviews revealed even though nursing staff observed and reported the above alleged abuse of Resident #1 by Resident #2, they were informed by the Administrator not to document the incidents, or conduct notifications to the Physician or Power of Attorneys (POAs) for Resident #1 and Resident #2.</p> <p>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 08/29/14 and was determined to exist on 07/26/14. The facility was notified of the Immediate Jeopardy on 08/29/14.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/2014, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The Immediate Jeopardy was verified to be removed on 09/03/14, prior to exiting the facility on 09/11/14, with remaining non-compliance at 42 CFR 483.13 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</p>	F 223	<p>10% of all resident records are being audited by the DON monthly to ensure that any notification issues have been identified and corrected regarding any resident change. The above mentioned audits are made part of the monthly QA meeting and will continue for the next 6 months.</p> <p>5. 09-15-14</p> <p>F 223</p> <p>It is and was on the days of survey the policy of Maysville Nursing and Rehabilitation Facility to assure residents are free from verbal, sexual, physical,</p>	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 223 Continued From page 18

Assurance program monitors to ensure residents are free from abuse.

The findings include:

Review of the facility's policy titled, "Abuse Reporting", undated, revealed the facility would not condone resident abuse by anyone, including other residents. Policy review revealed the definitions of abuse were provided to assist staff members in recognizing incidents of abuse, and sexual abuse was defined as, but not limited to, sexual harassment, sexual coercion, or sexual assault. Continued review of the facility's policy revealed, upon receiving a report of suspected abuse, the Charge Nurse was to examine and interview the resident, and record the findings of the examination in the resident's medical record. The Policy revealed upon receiving information concerning abuse, the Director of Nursing (DON) was to request a representative of the Social Services Department (SSD) monitor the resident's feelings concerning the incident and the resident's reaction to his/her involvement in the investigation. According to the Policy, any concerns and conversations were to be documented.

Record review for Resident #1 revealed the facility admitted him/her on 12/12/13, with diagnoses which included Dementia, Alzheimer's Disease, Anxiety and Diabetes. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 08/07/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of "00", which indicated the resident was severely cognitively impaired.

Record review for Resident #2 revealed the

F 223 and mental abuse, corporal punishment and involuntary seclusion.

- On 07-26-14, based on the report given to the Administrator by the charge nurse, "Resident #2 was noted to have his hand at the waist band of Resident #1's pants." Resident #1 was immediately protected. One-on-one supervision (for one hour) by activity staff and every fifteen minute checks were initiated on Resident #2 by nursing staff. On 07-28-14, it was reported that Resident #2 was noted to be "pulling on the shirt of Resident #1." Resident #2 was separated from

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 223 Continued From page 19

facility admitted the resident on 04/21/12, with diagnoses which included Difficulty Walking, Lack of Coordination, Cerebrovascular Disease, Dementia Without Behavioral Disturbances and Parkinson's Disease. Review of the Quarterly MDS Assessment, dated 06/26/14, revealed the facility assessed Resident #2 to have a BIMS score of fifteen (15) out of fifteen (15) indicated the resident was cognitively intact. Review of Resident #2's Comprehensive Care Plan revealed an undated problem for "social interaction impaired related to inappropriate behavior.

Interview with LPN #1 on 08/22/14 at 1:00 PM, revealed on 07/26/14 "sometime" after 2:00 PM, SRNA #1 reported to her a visitor had tapped the SRNA on the arm and said, "you need to do something about this", indicating Resident #1 and Resident #2. LPN #1 stated SRNA #1 reported to her, she observed Resident #1 and Resident #2 in the hallway where Resident #2 had his/her hand in the waist band of Resident #1's pants. Continued interview revealed LPN #1 reported SRNA #1's observations to the Administrator by telephone, and the Administrator told LPN #1 not to document the incident. LPN #1 stated when nurses made calls to the Administrator, they were told to document or not to document incidents by the Administrator. She stated the Administrator told her not to document Resident #2's behavior in the Nurse's Notes. LPN #1 declined to say if she had been told not to document something before, stating, "I would rather not answer that". LPN #1 revealed she had not physically assessed Resident #1 for any possible injuries after SRNA #1's reported allegation.

Interview with SRNA #1 on 08/25/14 at 4:35 PM,

F 223

Resident #1 and the fifteen minute checks continued. On 07-30-14, Resident #2 was admitted to the hospital for an inpatient psychiatric evaluation and returned to the facility on 08-04-14 at approximately 6:00 P.M. Resident # 2 was then readmitted to the hospital for a second inpatient psychiatric evaluation on 08-09-14 and returned to the facility on 08-12-14 at approximately 3:30 P.M. Resident #2 was moved to a separate unit of the facility on 08-12-14 upon return from second hospitalization. On 08-29-14, one-on-one was initiated and

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 223 Continued From page 20

revealed she observed Resident #2 being sexually inappropriate to Resident #1. She stated she observed Resident #2 having his/her hand inside the waist line of Resident #1's pants. Continued interview revealed a visitor touched her on the arm and said, "you might want to do something about this". SRNA #1 stated she did not remember the date of the incident, but thought it occurred between 4:30 PM and 5:00 PM. SRNA #1 indicated she had reported her observations to LPN #1.

A telephone interview with LPN #6 on 08/25/14 at 7:30 AM, revealed LPN #6 overheard the conversation between the visitor and SRNA #1 on 07/26/14, concerning the need for an intervention between Resident #1 and Resident #2. LPN #6 stated LPN #1/Charge Nurse telephoned the Administrator to report the incident and when LPN #1 got off the telephone with the Administrator she said the Administrator said not to document the incident in the Nurse's Notes. Continued interview with LPN #6 revealed, nurses were "supposed to call the Administrator" and she told the nurses "whether to document or not". LPN #6 stated she "honestly" did not know if there would be "reprisal" if she had documented the incident. According to LPN #6, she had heard from the Administrator not to document on other incidents; however, "would rather not discuss" that.

Continued review of Resident #2's Comprehensive Care Plan revealed the undated problem for "social interaction impaired related to inappropriate behavior" was updated on 07/26/14 regarding the resident being "redirected from room 129" (Resident #1's room) with an intervention for every fifteen (15) minute checks.

F 223

continues. A head to toe assessment for Resident #1 was documented on 07-29-14 by licensed staff and again on 08-05-14. Both assessments revealed skin was intact with "no issues noted", as evidenced by documentation. Resident #1 was immediately protected by the separation of him/her and Resident #2 on 7/26/14. Resident #2 was placed on 1:1 monitoring by nursing staff for one hour and then every 15 minute checks initiated by nursing staff.

2. All residents were interviewed by the Social Service Director on 08-30-14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 09/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 520 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 21

Review of the "Monitoring" forms revealed Resident #2 was on every fifteen (15) minute checks from 07/26/14 at 10:00 PM to 07/29/14 at 9:45 PM.

Even though Resident #2 was on every fifteen (15) minute checks, interview with LPN #2 on 08/21/14 at 1:20 PM, and on 09/10/14 at 9:50 AM, revealed on Monday, 07/28/14, SRNA #2 reported to her Resident #2 had his/her hand under Resident #1's shirt. She stated she did not consider this appropriate behavior, and indicated she reported the incident to the DON as soon as she was made aware of it. LPN #2 explained when an incident occurred, the nurse reported it to the Administrator or the DON and waited for instructions on what to do. Continued interview revealed LPN #2 did not document the incident because she was told in the morning shift change report not to document behaviors between Resident #2 and Resident #1. LPN #2 stated she did not feel comfortable with being told not to document Resident #2's behaviors toward Resident #1; however, she verbally passed it on to the next oncoming nurse, but did remember who that nurse was. Further interview revealed LPN #2 did not perform a physical exam on Resident #1 for possible injury and did not complete an Incident Report as per facility policy. There was no documented evidence LPN #2 took any action to ensure Resident #1 was protected from further potential abuse by Resident #2.

Interview with LPN #10 on 08/21/14 at 3:20 PM, revealed on 07/28/14 it was reported to her in shift change report by LPN #5 that Resident #2 was on every fifteen (15) minute checks because he/she had sexual behaviors towards Resident

F 223

and 09-03-14 asking if they had ever been touched inappropriately by a male resident or anyone since residing at the facility. The answers were unanimously "NO". Skin assessments are performed on all residents by licensed nursing staff on a weekly basis.

3. All staff (including Registered Nurses(RNs), Licensed Practical Nurses(LPNs), Certified Medication Technicians (CMTs), and State Registered Nursing Assistants (SRNAs) were in-serviced on 08-29-14 at 10:00 P.M., 08-30-14 at 10:00 A.M. and

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 223 | Continued From page 22

F 223

#1. She stated she was also told by LPN #5 in report not to document any inappropriate behavior by Resident #2. Continued interview revealed she did not feel comfortable with those instructions, but had passed the information along to the next nurse during shift report. Subsequent interview with LPN #10, on 09/04/14 at 3:10 PM, revealed the LPN #2/Charge Nurse told her Resident #2 was found in Resident #1's room with his/her hand up under the resident's shirt. LPN #10 stated LPN #2 told her she had called the DON because the Administrator was out of the facility.

Interview with LPN #5 on 08/24/14 at 8:30 PM, revealed she was told "in report" not to document resident behaviors in the Nurse's Notes, but was not sure who told her this. LPN #5 stated nurse were "supposed to call the Administrator or the DON for incidents and then receive instructions on what to do". LPN #5 reported nurses had "a list of incidents" which required "calling the Administrator" about. The Surveyor requested a copy of the list; however, a copy was never provided.

Interview with LPN #6 on 08/29/14 at 2:45 PM, revealed during a meeting on 07/30/14, at approximately 9:30 AM, LPN #11 came into the meeting and asked to speak to the DON outside of the room. Continued interview revealed after a few minutes the DON came back into the meeting and told the Administrator Resident #2 was "trying to go towards" Resident #1 again. According to LPN #6, the Administrator told her to call Resident #2's Physician and get an order to send the resident "out" to the hospital. LPN #6 indicated she notified the Physician as per the Administrator's instructions on 07/30/14.

on 08-30-14 at 2:00 P.M. by the Administrator and Director of Nursing covering the definition of abuse, reporting obligation of abuse allegations, identification of abuse, investigating abuse allegations and the implementation of the facility's Resident Protection Policy. This facility does not utilize agency staff. A question and answer period was held at the conclusion of all in-services to establish competency. On 8/29/14 an in-service was conducted by the Vice President of Clinical Services for the Administrator and Director of Nursing

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 23

Review of Resident #2's Comprehensive Care Plan revealed the undated problem for "social interaction impaired related to inappropriate behavior" was updated on 07/30/14 stating the resident was sent to the hospital psych unit.

Interview with SRNA #7 on 09/04/14 at 2:25 PM, revealed she had to redirect Resident #2 away from Resident #1's room three (3) to four (4) times daily before Resident #2 went out to the hospital on 07/30/14.

Interview with SRNA #8 on 09/04/14 at 2:22 PM, revealed she had redirected Resident #2 from Resident #1's room one or twice, maybe more often, before Resident #2 went to the hospital on 07/30/14.

Continued review of Resident #2's medical record revealed a "Patient Information" form, dated 07/30/14, which noted Resident #2 was transferred to the hospital on 07/30/14. Review of the Form revealed Resident #2's mental status was documented to be alert and oriented times three (3), which indicated the resident was alert and oriented to person, place and time. The Form noted Resident #2 had a BIMS score of ten (10) out of fifteen (15), which indicated the resident was now assessed as moderately cognitively impaired. Continued review of the Form revealed Resident #2 had displayed "inappropriate behaviors with females (touching inappropriately), difficult to redirect", and continued "to repeat behaviors." Review of the "Transfer and Discharge" form dated 07/30/14 revealed the reason checked for transfer was "the safety of individuals in our facility is endangered". Continued review of the "Transfer and Discharge"

F 223

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41066
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 24

form revealed the reason "...as set forth in the clinical record" was documented to be "inappropriate behaviors with females".

Review of Resident #2's hospital record revealed the resident was admitted to the hospital Behavioral Health Unit from the Emergency Room (ER) on 07/30/14 at 3:37 PM for sexually inappropriate behaviors with females, and on admission was alert to person, place and time. Continued review of the hospital records revealed Resident #2's history was taken by phone by the hospital's Licensed Clinical Social Worker (LCSW) from an unidentified facility Registered Nurse (RN). The LCSW documented Resident #1 recently had began to "experience sexualized behaviors" towards another resident who had Severe Alzheimer's Disease. Per the hospital documentation the facility RN told the hospital LCSW "for the past two (2) days" Resident #2 had been "wheeling" up to a "particular" resident and was touching his/her genital area without the resident's consent. Further review of the hospital record revealed Resident #2 was admitted to the hospital's Behavioral Health Unit because of the "seriousness" of the resident's "sexually aggressive behaviors". In addition, review of the hospital record revealed a Physician's Progress Note, dated 08/03/14 at 7:37 AM, which noted Resident #2 had a diagnosis of Hypersexuality. Hospital record review revealed the hospital discharged Resident #2 back to the facility on 08/04/14.

Further record review revealed the facility readmitted Resident #2 on 08/04/14 to the same room, on the same hall as Resident #1. Review of the Admission Nursing Assessment revealed the resident was assessed to be oriented to

F 223

8/30/14. There were twelve employees that were educated by the DON on 8/29/14 or 8/30/14 via telephone due to Family Medical Leave Act (FMLA), maternity leave or vacation. No employees were permitted to work until completion of in servicing as of 8/30/14. It is this facility's policy to educate all new employees on the "Resident Protection Policy" upon hire, and a minimum of two times annually in May and October. These in services are provided by the Human Resource Director, Administrator, DON, SSD and/or

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 223 Continued From page 25

person, place and time. Review of Resident #2's Comprehensive Care Plan revealed it had been revised to include an intervention for fifteen (15) minute checks to start on 08/04/14. However, review of the "Monitoring" forms revealed no documented evidence every fifteen (15) minute checks were completed from 08/04/14 through 08/08/14.

Staff interviews revealed on 08/04/14 after Resident #2's return from the hospital two (2) separate incidents occurred in which Resident #2 was observed, once by SRNA #7 and at another time by SRNA #2, with his/her hand up inside Resident #1's pant's leg.

Continued interview with SRNA #7 on 09/04/14 at 2:25 PM, revealed she observed Resident #2 in Resident #1's room on what she believed to be 08/04/14, the day Resident #2 was re-admitted to the facility from the hospital. SRNA #7 reported Resident #1's pant's leg was pulled up and Resident #2 had his/her hand up the pant's leg to the groin area. She stated she was uncertain who she had reported it to, but thought it was LPN #10.

Interview, on 08/21/14 at 3:20 PM and 09/04/14 at 3:10 PM, with LPN #10 revealed she indicated she had not had anything reported to her about Resident #2 having his/her hand in Resident #1's pants. She stated she recalled another nurse, LPN #2 reported to her Resident #2 had his/her hand up in Resident #1's shirt one (1) time; however, could not recall the exact date.

Interview with SRNA #2, on 08/21/14 at 1:20 PM, revealed she had observed Resident #2 in Resident #1's room on Monday, 08/04/14, the day

F 223

Ombudsman. Licensed nurses were educated on the definitions of abuse, reporting obligations of abuse allegations and the implementation of the facility's Resident Protection Policy which included the assessment of non-interviewable residents with any allegation of abuse. All new hires receive education on the facility's Resident Protection Policy during their orientation and again during their training period with the preceptor. There will be ongoing auditing and monitoring of facility staff to ensure knowledge of the facility's Resident

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 223 Continued From page 26

Resident #2 had returned from the hospital. The SRNA reported Resident #2 had more than half of his/her hand in the front of Resident #1's pants and stated, "no doubt" Resident #2's "fingers were touching" Resident #1's "pubic area". Continued interview revealed SRNA #2 reported the incident to LPN #2.

Interview, on 08/21/14 at 1:20 PM, on 09/09/14 at 3:50 PM and on 09/10/14 at 9:55 AM, with LPN #2 revealed she could only recall SRNA #2 informing her on 07/28/14 of Resident #2 having his/her hand up in Resident #1's shirt. She indicated she did not recall SRNA #2 informing her of any other incidents regarding Resident #2's behaviors.

Interview with SRNA #5, on 08/21/14 at 1:00 PM and on 09/04/14 at 2:45 PM, revealed approximately two (2) weeks prior to 08/21/14, uncertain of exact date, she had witnessed Resident #2 go into Resident #1's room and try to reach for the resident's genital area. She explained however, the overbed table was in the way and Resident #2 could not reach Resident #1's genital area. Continued interview revealed she and LPN #11 then intervened and removed Resident #2 from Resident #1's room.

Review of Resident #2's record revealed a Nurse's Note dated 08/09/14 timed 10:40 AM which stated Resident #2 "entered another female resident's room", was removed and sent to activities.

Interview with the Administrator on 08/29/14 at 3:45 PM, revealed on 08/09/14 it was reported to her Resident #2 was "trying" to go to Resident #1's room, was "easily redirected", but "when staff

F 223

Protection Policy through in-servicing. If a problem is identified at any time, immediate corrective action would occur. Competency of all staff will be established through daily reviews of resident status and evidence of the usage of the above mentioned tools. Daily reviews of all resident's status are achieved by review of any change in condition of any resident noted from the nursing communication sheets, acute monitoring log, physician's orders and incident reports, this will ensure that staff have identified the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 27

left" he/she would "go right back" to Resident #1's room. She stated she told staff to "go ahead and notify" the Physician and have Resident #2 sent back out to the hospital for another psych evaluation because of his/her "continued approaches" to Resident #1.

Review of Resident #2's "Monitoring" forms revealed on 08/09/14 every fifteen (15) minute checks were documented beginning at 10:45 AM which were documented until 1:45 PM, and at 2:00 PM it was documented the resident was out of the facility. Review of the Transfer and Discharge Form, dated 08/09/14, revealed Resident #2 was transferred back to the hospital with the reason checked for transfer as "the safety of individuals in our facility is endangered". Continued review of the "Transfer and Discharge" form revealed the reason Resident #2 was transferred to the hospital was for "inappropriate behaviors toward female residents". Review of the "Patient Information" form, dated 08/09/14, revealed Resident #2's mental status was documented to be alert, and had "again went to female room-intending inappropriate behavior".

Review of the hospital record for Resident #2 revealed the resident was again admitted to the hospital Behavioral Health Unit on 08/09/14 at 3:07 PM. Review of the Physician's Note, dated 08/09/14 at 3:20 PM, revealed Resident #2 had stated he/she had been a "bad boy" and was touching the ladies. Continued review of the Note revealed Resident #2 had also stated he/she had been trying to touch the ladies for a long time and finally "got my hands on one today". Continued review of the hospital record revealed Resident #2 was assessed by hospital staff to be alert to person and place, and to the current President.

F 223

change and react appropriately by completing an SBAR "Stop & Watch" form. All staff were re-educated on SBAR and "Stop & Watch" by the Administrator and DON on 8/29/14 and 8/30/14 and instructed that one copy is to be given to the charge nurse and the other copy be given to the DON. If there are questions related to alleged abuse during the daily review, the Administrator will review the clinical record as needed. Any identified concerns will be followed up with staff re-education. Competency will be

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 28

Record review revealed the facility readmitted Resident #2 to the facility on 08/12/14 with diagnoses of Hypersexuality and Dementia with Behavior Disturbances. Review of the Admission Nursing Assessment, dated 08/12/14, revealed Resident #2 was oriented to person, place and time on readmission to the facility.

Interview with Resident #2 on 08/20/14 at 7:08 PM, revealed the resident was aware he/she had touched Resident #1 inappropriately, and stated, "I touched someone I was not supposed to". Continued interview revealed Resident #2 reported he/she "liked" Resident #1, and did not know how many times he/she had touched Resident #1. Resident #2 stated he/she touched Resident #1 "here", and pointed and rubbed his/her hand over the genital area. Resident #2 further reported touching Resident #1 inside his/her clothes.

Interview with with Resident #1's POA on 08/22/14 at 12:15 PM, revealed he was visiting one night and was told by a nurse, who no longer worked at the facility, Resident #1 had been approached in the hallway by another resident, but nothing happened and the nurse said it was not a "sexual thing". He stated he had not been told of any other incidents, and reported he was unaware there were other incidents.

Interview with Resident #2's POA, on 09/04/14 at 10:20 AM, revealed she could not remember the date she was notified of an incident regarding inappropriate behavior by the resident towards another resident.

Interview with Resident #1's and Resident #2's

F 223

established with respect to new hires through signature on the 'Policy for Adult Protection' form that this policy is thoroughly reviewed and a question and answer session between staff and instructor. The elements of the facility's 'Resident Protection Policy' are reviewed on each employee's annual evaluation by their supervisor. In addition, the facility provides employees with an informational card that can attach to their name tag or be kept in their pocket which includes the elements of the "Resident

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 223 Continued From page 29

attending Physician, on 08/20/14 at 4:00 PM, revealed he became aware of Resident #2's sexual behaviors toward Resident #1 on 07/30/14, and gave an order to send Resident #2 to the hospital for a psych evaluation. The Physician indicated he was only aware of Resident #2's behaviors on 07/30/14 and on 08/09/14.

Interview with the Social Service Director (SSD), on 08/22/14 at 10:00 AM, revealed she indicated she was told that Resident #2 was going into Resident #1's room on 07/30/14, but was not told anything else about Resident #2's behaviors. The SSD stated no other residents had made any complaints about Resident #2; therefore, she did not investigate or interview other residents and no one asked her to investigate or question the residents. She further stated she was uncertain if any other residents were questioned or examined. Continued interview revealed if there was an incident, the Administrator would ask her to conduct interviews with the staff and residents. However, the Administrator did not ask her to investigate any incidents involving Resident #1 and Resident #2.

Interview with the DON, on 08/22/14 at 10:20 AM and on 08/29/14 at 7:40 PM, at 8:00 PM and 8:30 PM, revealed she was first notified of Resident #2's behaviors towards Resident #1 on 07/28/14 "around noon". She stated she "immediately" texted the Administrator who sent the Social Worker to perform a BIMS on Resident #2. The DON revealed it was reported to her Resident #2 had been sitting in Resident #1's "doorway in the hall pulling on" Resident #1's shirt. She stated she couldn't say if family or the Physician was notified because "nothing happened", and the

F 223

Protection Policy" as an additional resource.

4. A QA process has been implemented as of 08-29-14 by the Administrator to monitor on a continual basis, the residents' condition through daily morning meetings where the Administrator, Director of Nursing, Assistant Director of Nursing, charge nurses, Administrative nurses, MDS Coordinator, SSD, Activity Director, and therapy team meets. The Administrator, DON, and/or ADON will review all incident reports, nursing report sheets, acute monitoring logs,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 223 Continued From page.30

Administrator did not instruct anyone that she was aware of to start and investigation. According to the DON, the every fifteen (15) minute checks were continued, an assessment was performed on Resident #2 to determine the reason for the change in the resident's behavior. She stated it was her "understanding" there was "no distress" noted to Resident #1 per the nurses; therefore she did not conduct an assessment of Resident #1 for potential injury. The DON stated she had not "talked" to Resident #2 "about the incident". Per interview, she stated no physical examinations were performed on other non-interviewable residents after the incidents which occurred prior to Resident #2 being sent out to the hospital on 07/30/14. She stated she was told in the "morning meeting" on 07/30/14 Resident #2 was "seeking out" Resident #1. Continued interview with the DON revealed on 07/30/14, Resident #2 was observed "heading towards" Resident #1's room, was stopped by staff and redirected to an activity and the Administrator "moved forward" with sending Resident #2 out to the hospital.

Interview with the Administrator on 8/29/14 at 3:45 PM and at 6:45 PM, revealed on 07/26/14 "in the evening" it was the first time she was informed of Resident #2 having "inappropriate sexual behaviors". The Administrator reported the "first thing" staff told her on 07/26/14 was Resident #2 had his/her hands "down" Resident #2's pants; however, after she asked questions it was "said" Resident #2 had his/her "fingers in the waistband" of Resident #1's pants. She stated she thought it was LPN #6 who called and reported this to her; however, stated she had no documentation of the phone call. The Administrator revealed she told LPN #8 to keep

F 223

SBAR forms, and physician's orders to identify potential incidents involving alleged abuse and ensure the "Resident Protection Policy" is followed as required. Any allegations of abuse will be reported immediately to required state agencies. This will ensure physician notification, care plan updates, clinical records or any allegations of verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment and involuntary seclusion are immediately reported to the Administrator, investigated and

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 223 Continued From page 31
Resident #2 on one on one (1:1) observations until she called her back. The Administrator stated she called and spoke to the Corporate Nurse, and then called the facility and spoke to LPN #1 and told her to initiate every fifteen (15) minute checks. She stated she asked if there were any other changes to Resident #2, and LPN #1 told her "no, not really". Per interview, the Administrator stated she asked LPN #1 what Resident #2's last assessed BIMS were, and LPN #1 told her fifteen (15). She stated the two (2) residents should have been separated and protected. The Administrator stated she had not felt Resident #2's behaviors were "willful at any time" because when he/she was "questioned", he/she didn't "answer appropriately to the questions being asked" which "showed cognitive impairment". She stated the every fifteen (15) minute checks were how the facility "felt" they had "kept the residents safe". According to the Administrator, the DON reported to her on 07/28/14 a nurse had told her Resident #2 had "hold of" Resident #1's shirt, "pulling on the bottom of the shirt". The Administrator explained she asked the DON if a physical assessment was completed on Resident #2 to try to determine the "root cause" for the "changes" in his/her behaviors. The Administrator indicated a physical assessment of Resident #2 was completed, and LPN #2 reported the assessment did not reveal "any reason for the changes". She stated she had the Social Worker reassess Resident #2's BIMS on 07/28/14, and the Social Worker reported the resident's BIMS as "seven (7)" after the reassessment. Per interview, it was reported to the DON on 07/30/14 Resident #2 was "continuing to seek" out Resident #1. Resident #2 had gone to Resident #1's doorway and was reaching toward him/her. She stated the DON

F 223 reported to the appropriate state agencies. The daily morning meetings are conducted Monday through Friday and the audits are completed by the Administrator. In the absence of the Administrator, the DON and/or ADON, or charge nurse will conduct the audits. The charge nurses complete the process on the weekends. The results of the audit from the weekend charge nurses are reviewed by the Administrator, DON or ADON on the following work day. The Administrator has the documentation of the completion of the daily audits and the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID-PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID-PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 223 Continued From page 32

notified her of this information, and she had "them" call the Physician for "a psych eval". The Administrator revealed Resident #2's Physician had been "updated" of Resident #2's "inappropriate sexual behavior" on 07/29/14; however, there was no documentation of when the Physician was first notified.

Continued interview with the Administrator on 08/29/14 at 3:45 PM revealed Resident #2 returned to the facility on 08/04/14, with no "report" of behaviors or issues, and "appeared" to be the same "as we all knew" him/her, friendly and cooperative. The Administrator stated, however, on 08/09/14 after she was notified of Resident #2 still trying to go into Resident #1's room, being redirected out of the room and going right back, Resident #2 was sent to the hospital again for another psych eval.

She stated Resident #2 was readmitted to the facility, 08/12/14, to another unit after the last hospitalization for psych evaluation and there had been no further "episodes of behaviors" towards other residents. The Administrator stated she had not told the nurses not to document or not to report Resident #2's behaviors towards Resident #1.

Additional interview with the Administrator, on 09/04/14 at 7:50 PM, revealed she was uncertain why the every fifteen (15) minute checks for Resident #2 were not performed and documented as being done for 08/04/14 through 08/08/14; however, stated the fifteen (15) minute checks should have been completed. She stated the every fifteen (15) minutes checks of Resident #2 were how the facility felt they kept Resident #1 safe.

F 223

weekend audit documentation from charge nurses is forwarded to the Administrator for review. In summary, the review of this information daily and discussions of resident changes will alert the Administrator to any situation which would require reporting alleged abuse and protection of residents and any need for staff re-education and follow-up. This QA process will be ongoing. The Social Service Director interviews all residents quarterly based on their MDS schedule. During each interview, residents are interviewed to identify

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	<p>Continued From page 33</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14 that alleged removal of the IJ effective 09/03/14. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. Resident #1 was assessed by means of a head to toe skin assessment on 07/28/14 by an LPN, and again on 08/05/14. Both skin assessments indicated Resident #1's skin was intact with no redness. A complete assessment of Resident #1 was conducted by the Physician on 07/31/14 and documented as follows: "advanced dementia, otherwise, no significant issues to deal with. Chart is reviewed. (Resident) is seen. Her exam is unchanged. Plans: for ongoing care by current written orders". 2. After the incident on 07/26/14, Resident #2 was removed from the area and 1:1 supervision (for one hour) by activities staff was provided, followed by every 15 minute checks by nursing staff. On 08/29/14 at 9:00 PM, 1:1 monitoring was initiated, as directed by the Administrator, for Resident #2. This will be ongoing. 3. On 08/29/14 at 9:15 PM, an in-service was conducted by the Vice President of Clinical Services for the Administrator and Director of Nursing (DON) on the following: definitions of abuse; reporting obligations related to abuse allegations; identification of abuse; investigation of abuse allegations; implementation of the facility's Resident Protection Policy; and accuracy of the clinical record. The Administrator and the DON were able to verbalize understanding of the education. 	F 223	<p>any potential abuse of any type. The SSD attends daily morning meeting and is alerted to any resident changes such as mood, behavior, and physical or emotional which could be indicative of possible abuse. The SSD interviews any resident with the above noted changes as identified, or as needed, in addition to the quarterly assessment completed. In addition, licensed staff conducts weekly skin assessments on all residents which would also identify any concerns for interviewable or noninterviewable residents. Any concerns are reported</p>	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 223 Continued From page 34

4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30 AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.

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

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

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

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

F 223

to the Administrator for investigation. The results of the daily auditing and monitoring will be made part of the monthly QA meeting by the Administrator and will continue for the next 6 months.

5. 09-15-14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 35

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

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

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

F 223

Resident #1's son was contacted by the Vice

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 36

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

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

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

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

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

F 223

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 37

F 223

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

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

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

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

1. Copies of skin assessments, performed by licensed staff, for Resident #1 on 07/28/14 and 08/05/14 were reviewed. No concerns were revealed during this review. A review of the complete assessment by the Physician on 07/31/14 revealed no concerns.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 | Continued From page 38

F 223

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 | Continued From page 39

Interview with RN #2, on 09/11/14 at 1:25 PM, revealed she attended the in-service on 08/29/14 related to abuse, documentation, notification, reporting, identifying, investigating, and revision of care plans.

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

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

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

F 223

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 223 Continued From page 40
Interview with the POA for Resident #1, on 09/10/14 at 4:30 PM, revealed he had spoken with the Vice President of Clinical Services and told her we was aware of the inappropriate behavior toward his mother, as he had been told by facility staff.

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

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

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

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=J INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or

F 223 F225
It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to report alleged violations, conduct an investigation of all alleged violations, report the results to proper authorities and take necessary corrective actions.

1. The facility did not initiate a formal abuse investigation on 07-26-14 based on the report given to the Administrator by the charge nurse. "Resident #2 was noted to have his hand at the waist band of Resident #1's pants." Resident #1 was immediately protected. One-on-one supervision (for one hour) by activity staff and every fifteen

F 225

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 520 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 41
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.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure all

F 225
minute checks were initiated on Resident #2 by nursing staff. On 07-28-14, it was reported that Resident #2 was noted to be "pulling on the shirt of Resident #1." Resident #2 was separated from Resident #1 and the fifteen minute monitoring continued. In addition, the social services director completed a cognitive assessment, which revealed a BIMS score of 7 out of 15, which is indicative of severely impaired cognitive abilities. A complete skin assessment was also completed on Resident #1, with no issues noted on 07-29-14 by

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 42

allegations of resident to resident sexual abuse were thoroughly investigated, ensure allegations were immediately reported to the appropriate State Agencies, and to ensure residents were protected from further abuse for one (1) of eight (8) sampled residents (Resident #1).

Interviews with nurses and State Registered Nursing Assistants (SRNAs) revealed Resident #2 was observed touching Resident #1 inappropriately on several different occasions. On 07/26/14, a visitor pointed at Resident #1 and Resident #2 and told a SRNA "you need to do something about this", as Resident #2 was observed with his/her hand inside the waist band of Resident #1's pants. On 7/28/14, Resident #2 had his/her hand under Resident's #1's shirt. On 07/30/14 sought out Resident #1, displayed inappropriate behaviors (touching inappropriately), was difficult to redirect, and was sent out to the hospital for a psychiatric (psych) evaluation. On 08/04/14, Resident #2 was readmitted and was observed on two (2) separate times that day to have more than half of his/her hand in Resident #1's pants, once near Resident #1's pubic area down the front of his/her pants and the other time in the groin area up the pant's leg. In addition, staff interviews revealed Resident #2 tried unsuccessfully on other occasions to seek out Resident #1; however, staff intervened before he/she was able to touch Resident #1. On 08/09/14 Resident #2 was found in Resident #1's room again, redirected out of the room; however, continued to return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation. Interview and record review revealed the facility failed to reported these allegations of abuse to the appropriate State Agencies, failed to investigate

F 225

licensed staff. No allegations of sexual abuse or assault were reported. Resident #1 was immediately protected by the separation of him/her and Resident #2 on 7/26/14. Resident #2 was placed on 1:1 monitoring by nursing staff for one hour and then every 15 minute checks initiated by nursing staff.

2. All residents were questioned on 08-30-14 and 09-03-14, as to whether they had been touched inappropriately by a male resident or anyone since residing at the facility. The answers were unanimously "NO". Skin assessments are

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 43
the allegations and failed to protect residents from further potential abuse. The facility failed to investigate the incidents involving Resident #2 as possible sexual abuse and report the alleged abuse to the State Agencies. Therefore, the facility failed to ensure a physical examination of Resident #1 and other non-interviewable residents was performed to assess for possible injury, and failed to interview other interviewable residents regarding Resident #2's behaviors. (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, to ensure residents were protected from abuse and to immediately report the incidents to the appropriate State Agencies, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) was identified on 08/29/14 and was determined to exist on 07/26/14. The facility was notified of the Immediate Jeopardy on 08/29/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/2014, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The Immediate Jeopardy was verified to be removed on 09/03/14, prior to exiting the facility on 09/11/14, with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-225 at a Scope & Severity (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 all allegations of abuse were thoroughly investigated, and the allegations of abuse were immediately reported to the appropriate State Agencies.

F 225

performed on all residents by licensed staff on a weekly basis.
3. On 08-29-14 at 9:15 p.m., an in-service was conducted with the Administrator and Director of Nursing by the Vice President of Clinical Services, covering the definitions of abuse, reporting obligations of abuse, allegations, identification of abuse, investigations of abuse allegations and the implementation of the facility's Resident Protection Policy. All staff was in-serviced on 08-29-14 at 10:00 P. M., 08-30-14 at 10:00 A.M., and 08-30-14 at 2:00 P.M. by the Administrator and

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 44

The findings include:

Review of the facility's policy titled, "Abuse Reporting", undated, revealed the facility revealed the person observing an incident of resident abuse or suspecting resident abuse was to immediately report such incidents to the Charge Nurse and the Administrator or Director of Nursing (DON). Per the Policy, upon receiving a report of suspected abuse, the Charge Nurse "must" complete an Incident Report Form and obtain a "written, signed and dated statement from the person reporting the incident". The Policy stated "upon receiving reports of" abuse the Administrator or DON would "immediately" report the incident to the State Survey Agency, Adult Protective Services (APS) and other agencies as appropriate. Continued review of the Policy revealed an "immediate investigation" would be made and results provided to the Administrator within five (5) working days of the occurrence of the incident, and reported to the State Agencies within the five working days.

Review of the facility's policy titled, "Abuse Investigations", undated, revealed all reports of resident abuse, neglect and injuries of unknown source should be promptly and thoroughly investigated by facility management. The Policy stated the Administrator, or his/her designee would investigate alleged incidents and review completed documentation forms and review residents' medical records to determine events leading up to the incident. The Policy revealed the Administrator or his/her designee as part of the investigation would interview: the person(s) reporting the incident; any witness to the incident; the resident (as medically appropriate); staff on

F 225

Director of Nursing on the above mentioned topics. The in-services specifically reviewed the need to immediately report occurrences to the Administrator so an investigation can be initiated, if necessary. There were twelve employees that were educated by the Director of Nursing via phone due to FMLA, maternity leave or vacation. A question and answer period was held at the conclusion of each in-service to establish competency. With any allegation of abuse, the employee is required to report to the charge nurse who then reports the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 45 all shifts who had contact with the resident during the period of the alleged incident; the resident's roommate, family members, and visitors. Also, as part of the investigation the resident's Physician was to be consulted as needed to determine the resident's current level of cognitive function and medical condition, and all events leading up to the alleged incident were to be reviewed. Interview with staff revealed Resident #2 was seeking out Resident #1 and/or displaying inappropriate sexual behavior towards Resident #1 on 07/26/14, 07/28/14, 07/30/14, 08/04/14, and 08/09/14. Interview with LPN #1 on 08/22/14 at 1:00 PM, revealed she reported Resident #2's behavior towards Resident #1 on 07/26/14 to the Administrator and the Administrator told LPN #1 not to document the incident. LPN #1 stated when nurses made calls to the Administrator, they were told to document or not to document incidents by the Administrator. LPN #1 further revealed she had not physically assessed Resident #1 for any possible injuries and did not complete an Incident Report as per facility policy. Interview, on 08/21/14 at 1:20 PM and on 09/10/14 at 9:50 AM, with LPN #2 revealed she reported the incident on 07/28/14 to the DON as soon as she was informed. However, she did not document what happened because she was told in morning shift change report not to document behaviors between Resident #2 and Resident #1. LPN #2 revealed after reporting the incident to the DON, she had not performed a physical examination on Resident #1 for possible injury and had not completed an Incident Report after	F 225	allegation to the Administrator. The charge nurse and Administrator initiates the investigation immediately with assessment of the resident(s), interviews with any witnesses (which may be executed by Administrator, DON, ADON, supervisory staff- housekeeping supervisor, medical records supervisor, activity supervisor, MDS Coordinator, SSD, and licensed nurses), and notification of physician and responsible party. The completion of the formal investigation is conducted by the Administrator and/or		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 225 Continued From page 46.

the incident, as per facility policy. According to LPN #2, facility nurses waited for instructions from the Administrator or the DON on what to do.

Review of the "Patient Information" form, dated 07/30/14, revealed Resident #2 was transferred to the hospital due to "inappropriate behaviors with females (touching inappropriately), difficult to redirect", and continued "to repeat behaviors."

Interview with SRNA #7 on 09/04/14 at 2:25 PM, revealed she observed Resident #2 in Resident #1's room on what she believed to be 08/04/14, the day Resident #2 was re-admitted to the facility from the hospital. SRNA #7 reported Resident #1's pant leg was pushed up to his/her thigh, and Resident #2 had his/her hand up inside the pant leg to the groin area. She stated she was uncertain who she had reported it to, but thought it was LPN #10.

Interview, on 08/21/14 at 3:20 PM and 09/04/14 at 3:10 PM, with LPN #10 revealed she indicated she had not had anything reported to her about Resident #2 having his/her hand up in Resident #1's pant's leg. She stated she recalled another nurse, LPN #2 reported to her Resident #2 had his/her hand up in Resident #1's shirt one (1) time; however, could not recall the exact date.

Interview with SRNA #2, on 08/21/14 at 1:20 PM, revealed she had observed Resident #2 in Resident #1's room on 08/04/14, the day Resident #2 had returned from the hospital. The SRNA reported Resident #2 had more than half of his/her hand down the front of Resident #1's pants and stated, Resident #2's "fingers were touching" Resident #1's "pubic area". Continued interview revealed SRNA #2 reported the incident

F 225

DON and reported to appropriate agencies. All staff are educated on the reporting procedures of abuse allegations. The question and answer period at the conclusion of in services provided all staff the opportunity to ask any questions of material that wasn't clear to them. Answers were immediately given. One hundred percent of staff were educated on 8/29/14 or 8/30/14. There were twelve employees that were educated by the DON on 8/29/14 or 8/30/14 via telephone due to FMLA, maternity leave or vacation. No employees were

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 47
to LPN #2. However, there was no documented evidence the facility reported or investigated the allegation of sexual abuse.

Review of Resident #2's record revealed a Nurse's Note dated 08/09/14 which stated Resident #2 "entered another female resident's room". Interview with the Administrator on 08/29/14 at 3:45 PM, revealed on 08/09/14 it was Resident #2 was "trying" to go to Resident #1's room.

Requests were made by the State Survey Agency for any Incident Reports and investigations regarding Resident #2's alleged sexual abuse on 07/26/14 and 08/04/14; however, the facility denied the requests.

Interview with the DON on 09/10/14 at 10:00 AM, revealed it was facility policy to interview other residents and to interview, examine and not to bathe the alleged victim when there was an allegation of abuse. The DON stated she had texted the Administrator about the incident on 07/28/14. However, the DON stated the Administrator had not instructed anyone that she was aware of to start an investigation. According to the DON, no physical assessments were performed on Resident #1 or other non-interviewable residents, and no interviews with interviewable residents were conducted. The DON stated the Administrator had not informed her to complete an Incident Report, so she had not completed one (1).

Continued interview with the DON on 09/11/14 at 8:55 AM, revealed the facility always did Incident Reports on resident falls or skin tears; however for residents' behaviors it boiled down to whether

F 225 permitted to work until completion of in servicing as of 8/30/14. Licensed nurses were educated on the definitions of abuse, reporting obligations of abuse allegations and the implementation of the facility's Resident Protection Policy which included their responsibility of initiating an investigation of alleged abuse and the assessment of non-interviewable residents with any allegation of abuse on 8/29/14 and 8/30/14 by the Administrator and DON. All new hires receive education on the facility's Resident Protection Policy

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 225 Continued From page 48

there was an injury or not. She reported staff were supposed to complete an Incident Report on any behavior which caused physical or emotional injury. The DON stated typically, if there was not an injury and the incident did not affect the resident emotionally an Incident Report was not done. Per interview, she stated staff was instructed to call the Administrator if a behavior occurred, and the Administrator decided if it was reportable or not. The DON revealed if an incident occurred the resident was assessed and typically Social Services followed up with all incidents. Per interview, she stated she did not train the facility's nurses that all incidents were to be put on Incident Reports, such as skin tears which were not put on Incident Reports.

Interview with the Social Service Director (SSD), on 08/22/14 at 10:00 AM, revealed she was told that Resident #2 was going into Resident #1's room, but was aware of Resident #2's behaviors. Continued Interview revealed the Administrator did not ask her to investigate any incidents involving Resident #1 and Resident #2.

Further interview with the Administrator, on 09/04/14 at 7:50 PM, revealed she did not have staff complete Incident Reports because she did not see the incidents with Resident #1 and Resident #2 as reportable. She stated it was up to the nurses and their nursing judgement whether or not to document residents' behaviors. The Administrator revealed the facility's policy was to report incidents of abuse immediately, but she did not consider the incidents involving Resident #2 as abuse because occasionally the resident was confused; therefore, no investigations were completed.

F 225

during their orientation and sign review and understanding of the Adult Protection policy and again during their training period with the preceptor.

4. A QA process has been implemented as of 08-29-14 by the Administrator to monitor on a continual basis, the residents' condition through daily morning meetings where the Administrator, Director of Nursing, Assistant Director of Nursing, charge nurses, SSD, Activity Director, MDS Coordinator, administrative nurses and therapy team meet. The

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 49
The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/14 that alleged removal of the IJ effective 09/03/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was assessed by means of a head to toe skin assessment on 07/28/14 by an LPN, and again on 08/05/14. Both skin assessments indicated Resident #1's skin was intact with no redness. A complete assessment of Resident #1 was conducted by the Physician on 07/31/14 and documented as follows: "advanced dementia, otherwise, no significant issues to deal with. Chart is reviewed. (Resident) is seen. Her exam is unchanged. Plans: for ongoing care by current written orders".
2. After the incident on 07/26/14, Resident #2 was removed from the area and 1:1 supervision (for one hour) by activities staff was provided, followed by every 15 minute checks by nursing staff. On 08/29/14 at 9:00 PM, 1:1 monitoring was initiated, as directed by the Administrator, for Resident #2. This will be ongoing.
3. On 08/29/14 at 9:15 PM, an in-service was conducted by the Vice President of Clinical Services for the Administrator and Director of Nursing (DON) on the following: definitions of abuse; reporting obligations related to abuse allegations; identification of abuse; investigation of abuse allegations; implementation of the facility's Resident Protection Policy; and accuracy of the clinical record. The Administrator and the DON were able to verbalize understanding of the education.
4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30

F 225 Administrator, DON, and/or ADON will review all incident reports, nursing report sheets, acute monitoring logs, SBAR forms, and physician's orders to identify potential incidents involving alleged abuse and ensure the "Resident Protection Policy" is followed. Any allegations of abuse will be reported immediately to required state agencies. The review of this information daily and discussions of resident changes will alert the Administrator to any situation which would require reporting alleged abuse and

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225: Continued From page 50

AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.

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

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

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

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

F 225: protection of residents. The results of the daily auditing and monitoring will be made part of the monthly QA meeting by the Administrator and will continue for the next 6 months. The facility also utilizes the Interact II Stop and Watch Program to gather input from all staff as to any changes noted or observed with any resident's behavior or otherwise. In the absence of the Administrator, the Director of Nursing, Assistant Director of Nursing or charge nurse will assume this responsibility. For continued monitoring of this alleged

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 51

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

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

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

Resident #1's son was contacted by the Vice President of Clinical Services at 4:00 PM on

F 225

deficient practice, a member of the governing body, which will be either the Executive Vice President or Vice President of Clinical Services, will be in attendance at the monthly quality assurance meetings for the next three months. There will be ongoing auditing and monitoring of facility staff to ensure knowledge of the facility's Resident Protection Policy through in-servicing. If a problem is identified at any time, immediate corrective action would occur. All department supervisors, charge nurses and

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

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0351

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 225: Continued From page 52

08/30/14 to ensure he was aware of the above concerns. He stated he was aware and had been notified by facility staff. No other concerns were expressed.

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

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

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

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

F 225

administrative staff (MDS assessment nurses and nurse aide coordinator) will periodically question staff on the facility's Resident Protection Policy to ensure staff is competent and understands all elements of the policy. Once a Stop and Watch tool has been initiated by a staff member, one copy is immediately given to the licensed nurse and the other copy is given to the DON for follow up and discussed in the interdisciplinary daily morning meeting. All staff of the facility were trained when the program was initiated and periodically thereafter. All new

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 53

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

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

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

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

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

F 225

employees are trained during their orientation period. Any resident that experiences a change in condition is reviewed for the effective use of the Interact II program including the Stop and Watch tool and the SBAR form. Licensed nurses conduct an assessment of the resident(s) noted on the Stop and Watch for a change in condition. If the assessment leads to further concerns related possible abuse, the licensed nurse will then initiate the facility's Resident Protection Policy, including a proper investigation, protection and reporting procedures.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 54

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

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

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

F 225

Through the daily morning meetings and audits, any concern noted from the review of nursing report sheets, incident reports, and physician's orders would be investigated and immediate action occur if necessary. The daily morning meetings are conducted Monday through Friday and the audits are completed by the Administrator. In the absence of the Administrator, the DON and/or ADON, or charge nurse will conduct the audits. The charge nurses complete the process on the weekends. The results of the audit from the weekend

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 225 Continued From page 55

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

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

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

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

Interview with the POA for Resident #1, on

F 225

charge nurses are reviewed by the Administrator, DON or ADON on the following work day. The Administrator has the documentation of the completion of the daily audits and the weekend audit documentation from charge nurses is forwarded to the Administrator for review. Any issues noted through this process regarding notification will immediately be followed up on and the appropriate actions occur. This QA process will be ongoing. The results of the daily auditing and monitoring will be made part of the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 225 Continued From page 56
09/10/14 at 4:30 PM, revealed he had spoken with the Vice President of Clinical Services and told her we was aware of the inappropriate behavior toward his mother, as he had been told by facility staff.

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

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

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

F 226 483.13(c) DEVELOP/IMPLMENT
SS=J 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.

F 225 monthly QA meeting by the Administrator and will continue for the next 6 months.
5. 9-15-14

F 226 F 226
It is and was on the days of survey the policy or Maysville Nursing and Rehabilitation Facility to develop and implement

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226 Continued From page 57

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 failed to have an effective system to ensure policies and procedures were implemented related to abuse for one (1) of eight (8) sampled residents (Resident #1).

Interviews with nurses and State Registered Nursing Assistants (SRNAs) revealed Resident #2 was observed touching Resident #1 inappropriately on several different occasions. On 07/26/14, a visitor pointed at Resident #1 and Resident #2 and told a SRNA "you need to do something about this", as Resident #2 was observed with his/her hand inside the waist band of Resident #1's pants. On 7/28/14, Resident #2 had his/her hand under Resident's #1's shirt. On 07/30/14 sought out Resident #1, displayed inappropriate behaviors (touching inappropriately), was difficult to redirect, and was sent out to the hospital for a psychiatric (psych) evaluation. On 08/04/14, Resident #2 was readmitted and was observed on two (2) separate times that day to have more than half of his/her hand in Resident #1's pants, once near Resident #1's pubic area down the front of his/her pants and the other time in the groin area up the pant's leg. In addition, staff interviews revealed Resident #2 tried unsuccessfully on other occasions to seek out Resident #1, however, staff intervened before he/she was able to touch Resident #1. On 08/09/14 at 10:40 AM Resident #2 was found in Resident #1's room again, redirected out of the room, however, continued to

F 226

written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident's property.

1. The facility did not initiate a formal abuse investigation on 07-26-14 based on the report given to the Administrator by the charge nurse. Resident #2 was noted to have his hand at the waist band of Resident #1's pants while sitting in the south unit hallway. Resident #1 was immediately protected. One-on one supervision (for one hour) by activity staff and every fifteen minute checks were completed on Resident #2 by nursing staff. On 07-28-14, it was

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

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0361

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 226 Continued From page 58
return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation. Interview and record review revealed the facility failed to reported these allegations of abuse to the appropriate State Agencies, failed to investigate the allegations and failed to protect residents from further potential abuse. The facility failed to investigate the incidents involving Resident #2 as possible sexual abuse and report the alleged abuse to the State Agencies per the facility's policy and procedures. (Refer to F-223, F-225)

The facility's failure to have an effective system in place to implement its abuse policies and procedures to prevent abuse was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) was identified on 08/29/14 and was determined to exist on 07/26/14. The facility was notified of the Immediate Jeopardy on 08/29/14.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/09/2014, with the facility alleging removal of the Immediate Jeopardy on 09/03/14. The Immediate Jeopardy was verified to be removed on 09/03/14, prior to exiting the facility on 09/11/14 with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-226 at a Scope and Severity (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 policies and procedures are implemented to ensure residents are free from abuse.

The findings include:

F 226 reported that Resident #2 was noted to be "pulling on the shirt of Resident #1." Resident #2 was separated from Resident #1 and the fifteen minute monitoring continued. In addition, the social services director completed a cognitive assessment of Resident #2, which revealed a BIMS score of 7 out of 15, which is indicative of severely impaired cognitive abilities. A complete skin assessment was also completed on Resident #1 by licensed staff, with no issues noted on 07-29-14. No allegations of sexual abuse or assault were reported. Resident #1

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 226 Continued From page 59

Review of the facility's policies titled, "Abuse Reporting", undated, and "Abuse Investigations" undated, revealed the facility would not condone resident abuse by anyone including staff or other residents or visitors, and any incident of or suspicion of abuse was to be immediately reported to the Charge Nurse and the Administrator or Director of Nursing (DON). The Charge Nurse was to examine and interview the resident and document the findings in the medical record; complete an Incident Report form; and obtain a written, signed and dated statement from the person reporting the incident. The Administrator or DON was to immediately report the incident to the State Survey Agency, Adult Protective Services and other agencies as appropriate. The Administrator or his/her designee was to "immediately" and thoroughly investigate all reports of resident abuse, and the investigation was to include review of the residents' medical records and completed documentation forms. The Administrator or his/her designee was also to interview: the person(s) reporting the incident; any witness to the incident; the resident if medically appropriate; staff members on all shifts who had contact with the resident when the alleged incident occurred; the resident's roommate, family members, and visitors, and consult the Physician. The DON was to have Social Services (SS) monitor the resident. Results of the investigation were to be reported to the State Agencies within five (5) working days.

Interview revealed allegations of sexual abuse and/or inappropriate behavior by Resident #2 towards Resident #1, which were reported to occur on 07/26/14, 07/28/14, 07/30/14, 08/04/14, and 08/09/14, were not documented in the

F 226

was immediately protected by the separation of him/her and Resident #2 on 7/26/14. Resident #2 was placed on 1:1 monitoring by nursing staff for one hour and then every 15 minute checks initiated by nursing staff.

2. All residents were questioned on 08-30-14 and 09-03-14, as to whether they had been touched inappropriately by a male resident or anyone since residing here. The answer was unanimously "NO". Skin assessments are performed on all residents by licensed staff on a weekly basis.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226: Continued From page 60

medical record, incidents reports were not completed, Resident #1 was not assessed for potential injury, State Agencies were not notified, and investigations were not conducted per the facility's policy.

The State Survey Agency requested Incident Reports and investigations regarding Resident #2's alleged sexual abuse of Resident #1 for 07/26/14 and 08/04/14; however, the facility denied the request and did not provide the requested documentation. Therefore, no documented evidence of an investigations by the facility as per facility policy was provided to the State Survey Agency for review.

Interview with LPN #1 on 08/22/14 at 1:00 PM, with LPN #6 on 08/25/14 at 7:30 AM, LPN #2 on 08/21/14 at 1:20 PM, and on 09/10/14 at 9:50 AM, LPN #10 on 08/21/14 at 3:20 PM, LPN #5 on 08/24/14 at 8:30 PM, revealed they were told not to document any inappropriate behavior by Resident #2. Further interview revealed Resident #1 was not assessed after each incident for potential injury and no incident reports were completed. However, per the facility's policy stated the Charge Nurse was to examine and interview the resident and document the findings in the medical record; complete an Incident Report form; and, obtain a written, signed and dated statement from the person reporting the incident. In addition, interviews with staff revealed the were to call the Administrator after each incident and the Administrator determined what should and should not be documented.

Interview with the DON on 09/10/14 at 10:00 AM revealed the Administrator led interviews and gave directions on who was to be interviewed

F 226: 3. On 08-29-14 at 9:15 p.m., an in-service was conducted with the Administrator and Director of Nursing by the Vice President of Clinical Services, covering the definitions of abuse, reporting obligations of abuse, allegations, identification of abuse, investigations of abuse allegations and the implementation of the facility's Resident Protection Policy and staff were re-educated on SBAR and "Stop & Watch" and instructed that one copy is to be given to the charge nurse and the other copy be given to the DON. All staff was in-serviced on 08-29-14 at 10:00 P. M., 08-30-

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 226 Continued From page 61
when incidents occurred.

Interview with the Administrator on 09/04/14 at 7:50 PM revealed she had not considered any of the incidents involving Resident #2 touching Resident #1 inappropriately as abuse as Resident #2 was sometimes confused. She stated she had never notified Resident #1's POA of any of the incidents as she hadn't considered it abuse, and first notified Resident #2's POA on 07/30/14 when the resident was sent out to the hospital.

Interview, on 08/22/14 at 10:00 AM, with the Social Service Director (SSD) revealed she had been told Resident #2 was going into Resident #1's room, and indicated Resident #2 was having "inappropriate behaviors" which were "not his norm" and he/she was "confused". The SSD stated she had not received complaints from any residents, therefore she had not investigated or interviewed other residents, as per facility policy. She stated she did not "just...go around asking questions", and was uncertain if any residents were questioned or examined after the incidents involving Resident #2. The SSD stated "usually" if an incident occurred the Administrator would ask her to conduct interviews with staff and residents; however the Administrator had not asked her to investigate any incidents involving Resident #2 and Resident #1.

Continued interview on 09/04/14 at 7:50 PM with the Administrator revealed she did not have staff complete Incident Reports because she did not see the incidents with Resident #1 and Resident #2 as reportable to State Agencies. The Administrator revealed the facility's policy was to report incidents of abuse immediately; however, she had not considered the incidents involving

F 226

14 at 10:00 A.M., and 08-30-14 at 2:00 P.M. by the Administrator and Director of Nursing on the above mentioned topics. The in-services specifically reviewed the need to immediately report occurrences to the Administrator so an investigation can be initiated if necessary. There were twelve employees that were educated by the Director of Nursing via phone due to FMLA, maternity leave or vacation. A question and answer period was held at the conclusion of each in-service to establish competency. The question and answer period at the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41058
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226 : Continued From page 62

Resident #2 as abuse because he/she was occasionally confused.

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

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

F 226

conclusion of in services provided all staff the opportunity to ask any questions of material that wasn't clear to them. Answers were immediately provided. One hundred percent of staff were educated on 8/29/14 or 8/30/14. There were twelve employees that were educated by the DON on 8/29/14 or 8/30/14 via telephone due to FMLA, maternity leave or vacation. No employees were permitted to work until completion of in servicing as of 8/30/14. Licensed nurses were educated on the definitions of abuse, reporting obligations of abuse

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226

Continued From page 63 education.

4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30 AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.

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

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

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

5. All resident records were reviewed by the DON, Minimum Data Set (MDS) staff, Admission Nurse, and administrative nurses, starting on 08/30/14 and ending on 09/02/14, to ensure

F 226

allegations and the implementation of the facility's Resident Protection Policy which included their responsibility of initiating an investigation of alleged abuse and the assessment of non-interviewable residents with any allegation of abuse. All new hires receive education on the facility's Resident Protection Policy during their orientation and again during their training period with the preceptor. All new hires provide their signature for review and understanding of the facility's Adult Protection policy.

4. A QA process has been implemented as

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 226 Continued From page 64

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

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

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

F 226

of 08-29-14 by the Administrator to monitor on a continual basis, the residents' condition through daily morning meetings where the Administrator, Director of Nursing, Assistant Director of Nursing, SSD, Activity director, administrative nurses, charge nurses and therapy team review physician's orders, nursing supervisor reports, 24 hour nursing communication sheets and incident reports. The facility also utilizes the Interact II Stop and Watch Program to gather input from all staff as to any changes noted

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41056	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226 Continued From page 65

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

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

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

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

The facility will also utilize the Interact II Stop and Watch Program to gather input from all staff

F 226

or observed with any resident's behavior or otherwise. In the absence of the Administrator, the Director of Nursing, Assistant Director of Nursing or charge nurse will assume this responsibility. For continued monitoring of this alleged deficient practice, a member of the governing body, which will be either the Executive Vice President or Vice President of Clinical Services, will be in attendance at the monthly quality assurance meetings for the next three months. It is this facility's policy to educate all new employees of the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226 Continued From page 66

regarding any changes noted or observed with any resident's behavior or otherwise.

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

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

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

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

1. Copies of skin assessments, performed by licensed staff, for Resident #1 on 07/28/14 and 08/05/14 were reviewed. No concerns were revealed during this review. A review of the complete assessment by the Physician on 07/31/14 revealed no concerns.
2. A review of every 15 minute checks of Resident #2 by nursing staff, for the period of 07/26/14 through 07/30/14, revealed no concerns. Observation of Resident #2 on 09/04/14 at 10:06 AM, revealed the resident to be sitting in the dining room with a staff member playing cards. Interview with SRNA #6 on 09/04/14 at 10:09 AM, revealed she was assigned to do 1:1 with Resident #2. Interview with the Administrator on 09/11/14 at 1:55 PM, confirmed Resident #2 was started on 1:1

F 226

"Resident Protection Policy" upon hire, and a minimum of two times annually in May and October. These in services are provided by the Human Resource Director, Administrator, DON, SSD and/or Ombudsman. In addition, the facility provides employees with an informational card that can attach to their name tag or be kept in their pocket which includes the elements of the "Resident Protection Policy" as an additional resource. There will be ongoing auditing and monitoring of facility staff to ensure knowledge of the

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 226 Continued From page 67
monitoring on 08/29/14 and the monitoring was ongoing.

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

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

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

F 226 facility's Resident Protection Policy through in-servicing and periodic questioning of staff by charge nurses, administrative staff (MDS assessment nurses and nurse aide coordinator) and department supervisors. A minimum of 25% of employees are questioned, and then in serviced monthly by their department supervisor on the "Resident Protection Policy" and SBAR "Stop & Watch". If a problem is identified at any time, immediate corrective action would occur. The Social Service Director interviews all

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 226: Continued From page 68

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

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

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

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

F 226:

residents quarterly based on their MDS schedule. The SSD attends daily morning meeting and is alerted to any resident changes such as mood, behavior, and physical or emotional which could be indicative of possible abuse. The SSD interviews any resident with the above noted changes as identified, or as needed in addition to the quarterly assessment completed. During each interview, residents are interviewed to identify any potential abuse of any type. In addition, licensed staff conducts weekly skin assessments on all residents which would

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

<p>F 226</p>	<p>Continued From page 69 actions taken by the facility.</p> <p>Interview with the POA for Resident #1, on 09/10/14 at 4:30 PM, revealed he had spoken with the Vice President of Clinical Services and told her we was aware of the inappropriate behavior toward his mother, as he had been told by facility staff.</p> <p>8. Interview with the Attending Physician for Resident #1 and Resident #2, on 09/10/14 at 5:35 PM, revealed he had spoken with the Vice President of Clinical Services and was aware of Resident #2's change in behavior.</p> <p>9. Review of the Quality of Care meeting minutes revealed residents with identified skin areas were reviewed on 07/25/14 and 08/07/14. Interview with the Administrator, on 09/11/14 at 5:10 PM, revealed the team met daily to monitor care plan revisions, incident reporting, and appropriate notification of the Physician and POA. The medical record audit is scheduled to be initiated 09/17/14 and completed by the end of each month. Review of the audit tool utilized to monitor 10% of resident records for accuracy on a monthly basis revealed no concerns.</p> <p>10. Interview with the Vice President of Clinical Services on 09/11/14 at 5:00 PM, revealed she or the Executive Vice President of Clinical Services would attend the monthly QA meeting for three (3) months. Monthly QA meetings are scheduled 09/17/14, 10/15/14, and 11/19/14.</p> <p>F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>SS=J</p> <p>The resident has the right, unless adjudged</p>	<p>F 226</p> <p>F 280</p>	<p>also identify any concerns for interviewable or noninterviewable residents. During the monthly Resident Council meetings, the residents are presented questions related to mistreatment or inappropriate behaviors from other residents or staff. Any concerns are reported to the Administrator for investigation. Once a Stop and Watch tool has been initiated by a staff member, one copy is immediately given to the licensed nurse and the other copy is given to the DON for follow up. All staff of the facility were trained when the program was initiated</p>	
--------------	---	---------------------------	---	--

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 280 Continued From page 70.
incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure the Comprehensive Care Plan was reviewed and revised to implement interventions to provide appropriate supervision of residents and protect residents from abuse for two (2) of eight (8) sampled residents (Residents #1 and #2).

Interviews with nurses and State Registered Nursing Assistants (SRNAs) revealed Resident #2 was observed touching Resident #1 inappropriately on several different occasions. On 07/26/14, a visitor pointed at Resident #1 and Resident #2 and told a SRNA "you need to do

F 280 in August 2011 and all new employees are trained during their orientation period. All staff will be educated a minimum of twice annually on the SBAR tool and "Stop & Watch" and as needed. The Administrator, DON, ADON and/or department supervisors (housekeeping supervisor, dietary supervisor, medical records supervisor, activity supervisor, MDS Coordinator, SSD, and Maintenance Director) will conduct these trainings. All staff were re-educated on SBAR and "Stop & Watch" and instructed that one copy is to be given to the charge

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 280 Continued From page 71
something about this", as Resident #2 was observed with his/her hand inside the waist band of Resident #1's pants. On 7/28/14, Resident #2 had his/her hand under Resident's #1's shirt. On 07/30/14 sought out Resident #1, displayed inappropriate behaviors (touching inappropriately), was difficult to redirect, and was sent out to the hospital for a psychiatric (psych) evaluation. On 08/04/14, Resident #2 was readmitted and was observed on two (2) separate times that day to have more than half of his/her hand in Resident #1's pants, once near Resident #1's pubic area down the front of his/her pants and the other time in the groin area up the pant's leg. In addition, staff interviews revealed Resident #2 tried unsuccessfully on other occasions to seek out Resident #1; however, staff intervened before he/she was able to touch Resident #1. On 08/09/14 Resident #2 was found in Resident #1's room again, redirected out of the room; however, continued to return. Resident #2 was sent back out to the hospital on 08/09/14 for another psych evaluation. Interview and record review revealed the facility failed to revise Resident #2's and Resident #1's care plans to provide adequate supervision and protection to prevent further incidents. (Refer to F-223)

The facility's failure to have an effective system in place to ensure the Comprehensive Care Plan was reviewed and revised to implement interventions to provide adequate supervision and protection to prevent further incidents was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 08/29/14 and was determined to exist on 07/26/14.

F 280

nurse and the other copy be given to the DON. This re-education took place on 8/29/14 and 8/30/14 by the Administrator and DON. Any resident that experiences a change in condition is reviewed for the effective use of the Interact II program including the Stop and Watch tool and the SBAR form. Licensed nurses conduct an assessment of the resident(s) noted on the Stop and Watch for a change in condition. If the assessment leads to further concerns related possible abuse, the licensed nurse will then initiate the facility's Resident

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F-280

Continued From page 72

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

The findings include:

Review of the facility's policy titled, "Care Plans-Comprehensive" dated 08/01/13, revealed care plans were developed based on a thorough assessment which included the the Minimum Data Set (MDS) Assessment. Continued review revealed care plan interventions were designed after careful consideration of the relationship between the resident's problem areas and their causes. Policy review revealed however, assessments of residents were ongoing and care plans were revised regarding the resident and the resident's condition changed. The Policy revealed the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when the desired outcome was not met.

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

F 280

Protection Policy; including a proper investigation, protection and reporting procedures. Through the daily morning meetings and audits, any concern noted from the review of nursing report sheets, incident reports, and physician's orders would be investigated and immediate action occur if necessary. The daily morning meetings are conducted Monday through Friday and the audits are completed by the Administrator. In the absence of the Administrator, the DON and/or ADON, or charge nurse will conduct the audits.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280: Continued From page 73

1. Record review revealed the facility admitted Resident #2 to the facility on 04/21/12, with diagnoses which included Dementia Without Behavioral Disturbances, Diabetes and Parkinson's Disease. Review of the Quarterly MDS Assessment dated 06/26/14, revealed the facility assessed Resident #2 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) which indicated the resident was cognitively intact.

Review of Resident #2's Comprehensive Care Plan, revealed the resident was care planned for social interaction impaired related to inappropriate behavior which was undated. Review revealed on 07/26/14 this care plan was updated with redirecting Resident #2 from room 129 (where Resident #1 resided), and an intervention was implemented for every fifteen (15) minute checks. Continued review of the care plan revealed it was updated on: 07/30/14, with information regarding Resident #2 being sent to the hospital for a psych evaluation; 08/04/14, when the resident returned from the hospital, and the every fifteen (15) minute checks were once again implemented; 08/09/14 when Resident #2 was sent back out to the hospital for another psych evaluation; and 08/12/14 when the resident returned from hospital and an intervention implemented for a room change to another unit. However, review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include interventions to provide increased supervision of Resident #2 to prevent further alleged sexual abuse incidents towards Resident #1.

Review of the hospital record revealed Resident #2 was diagnosed with Hypersexuality, was

F 280

The charge nurses complete the process on the weekends. The results of the audit from the weekend charge nurses are reviewed by the Administrator, DON or ADON on the following work day. The Administrator has the documentation of the completion of the daily audits and the weekend audit documentation from charge nurses is forwarded to the Administrator for review. Any issues noted through this process regarding notification will immediately be followed up on and the appropriate actions occur. This QA

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 280 Continued From page 74.
discharged from the hospital and transferred back to the facility on 08/04/14. However, review of Resident #2's care plan revealed no documented evidence the care plan was revised to include the diagnosis of Hypersexuality with interventions put in place to address the problem. Review of the care plan revealed the facility again initiated every fifteen (15) minute checks of Resident #2.

Review of the hospital record for Resident #2 revealed the resident was again admitted to the hospital Behavioral Health Unit on 08/09/14 and readmitted to the facility on 08/12/14 with diagnoses of Hypersexuality. However, review of Resident #2's care plan revealed no documented evidence the care plan was revised to include the diagnosis of Hypersexuality with interventions put in place to address the problem.

2. Record review revealed the facility admitted Resident #1 to the facility on 12/12/13, with diagnoses which included Dementia, Alzheimer's Disease and Anxiety. Review of the Quarterly MDS Assessment dated 08/07/14, revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of "00" out of fifteen (15) which indicated the resident was severely cognitively impaired.

Review of Resident #1's Comprehensive Care Plan, dated 12/24/13, revealed numerous care plans in place. However, further review of the Comprehensive Care Plan revealed no documented evidence it was updated or revised for this severely cognitively impaired resident's protection and safety from further alleged sexual abuse by Resident #2.

Interview, on 09/11/14 at 8:40 AM, with the MDS

F 280

process will be ongoing. The results of the daily auditing and monitoring will be made part of the monthly QA meeting by the Administrator and will continue for the next 6 months.

5. 09-15-14

F280

It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to assess a resident using the quarterly review instrument at least every three months.

1. Resident #2's care plan was revised by the MDS nurse on the following dates: 07-26-14, 07-30-14, 08-04-14, and 08-28-14 with a problem of "inappropriate

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 Continued From page 75

Coordinator revealed MDS staff reviewed and revised care plans daily, Monday through Friday, from review of Physician's Orders and information from the morning meeting. The MDS Coordinator stated the floor nurses did not usually update or revise residents' care plans. She stated she did not remember Resident #2's alleged sexual abuse incidents being discussed in the morning meetings, and stated Resident #2's care plan did not address the alleged abusive behaviors. However, she indicated Resident #2's care plan should have been revised to address the alleged abusive behaviors.

Interview with the DON, on 09/11/14 at 8:55 AM, revealed care plans were reviewed and revised by the MDS staff as necessary from the daily morning meeting information and review of the Physician's Orders. She stated however, she was unsure if Resident #2's sexually abusive behaviors were discussed in the morning meetings, and indicated if not the MDS staff would not have known to review and revise his/her care plan.

Interview with the Administrator, on 08/29/14 at 6:45 PM, revealed changes in residents' conditions or behaviors were reported to all staff through every shift report. However, she stated MDS staff were responsible for updating and revising residents' care plans daily, Monday through Friday, based on review of the Physician's Orders and information obtained during the morning meeting. The Administrator revealed she did not think "floor staff" updated residents' care plans. She further stated the care plans for both Resident #1 and Resident #2 should have been revised.

F 280

behaviors" and interventions of every fifteen minute monitoring, transfer to hospital and a room/wing change. On 08-29-14 at 9:00 P. M., one-on-one monitoring for Resident #2's alleged targeting behavior was added to the care plan. Resident #2 was immediately placed on one on one monitoring following the incident on 7/26/14 and then every 15 minute checks were initiated through 7/30/14. Resident #2 was also transferred to St. Elizabeth to receive inpatient psychiatric evaluations on two occasions, 7/30/14 and 8/9/14. Resident #1

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 280 Continued From page 76

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

1. Resident #1 was assessed by means of a head to toe skin assessment on 07/28/14 by an LPN, and again on 08/05/14. Both skin assessments indicated Resident #1's skin was intact with no redness. A complete assessment of Resident #1 was conducted by the Physician on 07/31/14 and documented as follows: "advanced dementia, otherwise, no significant issues to deal with. Chart is reviewed. (Resident) is seen. Her exam is unchanged. Plans: for ongoing care by current written orders".
2. After the incident on 07/26/14, Resident #2 was removed from the area and 1:1 supervision (for one hour) by activities staff was provided, followed by every 15 minute checks by nursing staff. On 08/29/14 at 9:00 PM, 1:1 monitoring was initiated, as directed by the Administrator, for Resident #2. This will be ongoing.
3. On 08/29/14 at 9:15 PM, an in-service was conducted by the Vice President of Clinical Services for the Administrator and Director of Nursing (DON) on the following: definitions of abuse; reporting obligations related to abuse allegations; identification of abuse; investigation of abuse allegations; implementation of the facility's Resident Protection Policy; and accuracy of the clinical record. The Administrator and the DON were able to verbalize understanding of the education.
4. On 08/29/14 at 10:30 PM, 08/30/14 at 10:30

F 280

was assessed by means of head to toe skin assessment by licensed nurses on 7/29/14 and 8/5/14. The SSD attempted to interview Resident #1 on 8/7/14 and the assessment is documented with no issues noted. The nurse's notes include specific entries for Resident #1 on 7/27/14, 7/29/14, 7/30/14, 7/31/14, 8/1/14, 8/3/14, 8/5/14 indicating the he/she was exhibiting no distress or change in behavior.

2. All resident care plans were reviewed starting on 08-30-14 and ending on 09-02-14 by the Director of Nursing, MDS staff, Admissions Nurse and

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 Continued From page 77

AM and 08/30/14 at 1:00 PM, the Social Service Director, Dietary Manager, Activity Director and all licensed staff were in-serviced by the Administrator and the DON on accuracy of clinical records, as related to documentation and notification of the Physician and the Power of Attorney or legal representative.

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

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

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

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

F 280

Administrative nurses for completeness and accuracy. The DON, MDS staff, ADON/Admissions nurse, and administrative nurses audited all resident care plans to ensure accuracy to reflect current interventions and physician's orders through observation, communication of front line staff and comparison of documented needs in relationship to the care plan.

3. Daily, the Administrative team reviews the physician's orders, nursing supervisor reports, the 24 hour nursing communication sheets

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 09/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41066
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 Continued From page 78

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

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

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

Resident #1's son was contacted by the Vice President of Clinical Services at 4:00 PM on

F 280

and incident reports. The Interact II Stop and Watch Program is also used to ensure care plans are up to date and accurate. Nurses have been instructed to update the care plan by utilizing communication forms. All licensed nursing staff are responsible for revising resident care plans and were educated on ensuring the revision of care plans on 8/29/14 and 8/30/14 by the Administrator and DON. This process is completed by the licensed nurse utilizing a communication form and/or attaching a copy of the new order