

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

RECEIVED
PRINTED: 07/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2012
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NAME OF PROVIDER OR SUPPLIER THE RICHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An abbreviated survey investigating KY18721 and KY18755 was initiated on 07/12/12 and concluded on 07/16/12. The Division of Health Care unsubstantiated the allegations due to lack of sufficient evidence; however, related deficiencies were cited.	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 223 SS=E	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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 facility policy review it was determined the facility failed to ensure residents were free from abuse for two (2) of five (5) sampled and three (3) unsampled residents, Resident #1 and #5. It was reported Resident #1 suffered verbal abuse by the DON and Resident #5 suffered physical abuse by LPN #3. The findings include: Review of the facility's policy regarding Reporting Abuse to Facility Management, revealed the facility does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies	F 223	F-223 1. The facility was not made aware of the allegation against LPN #3 until July 11, 2012 at 1:00 a.m. LPN #3 denied any abusive situation with Resident #5. LPN #3 stated that he/she was only trying to provide safety for the resident and himself. Resident #5 was assessed by the nursing staff on by nursing staff on July 11, 2012 at 1:15 a.m. by LPN #4 and no reddened or bruised areas were noted. Resident #5 did not remember the incident	

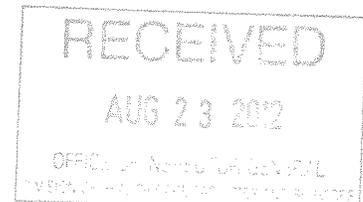
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Elisa [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/23/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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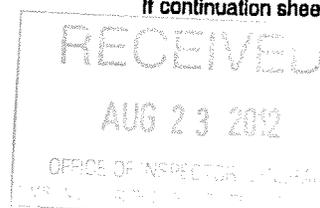
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F 223	<p>Continued From page 1</p> <p>serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.</p> <p>Review of the facility's policy regarding Protection of Residents During Abuse Investigation, revealed upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record.</p> <p>1) Review of the clinical record revealed the facility admitted Resident #5 on 08/01/09 with the diagnoses of Dementia and Immobilization Syndrome. The facility assessed the resident on the Minimum Data Set (MDS), dated 05/22/12, with a cognition score of five (5) meaning the resident had severe cognitive impairment.</p> <p>Interview with CNA #5, on 07/16/12 at 2:24 PM, revealed she was working with LPN #3 on 07/09/12 when he became rough with Resident #5. She stated he treated the resident roughly when trying to get him/her back in the bed by throwing his/her legs over the edge of the bed and then when the resident became upset over that he/she swung at LPN #3. She stated as the resident took a swing at LPN #3, he grabbed and put both of the residents arms across his/her chest and told him/her to stop. CNA #5 stated the resident swung at LPN #3 again and this time LPN #3 hit his/her on the arm, but not too hard. The resident then told LPN #3 that he/she was going to get his/her Daddy to come up there and LPN #3 responded to the resident by saying bring it. CNA #5 stated she reported the incident to her supervisor on 07/11/12 when the supervisor</p>	F 223	<p>with LPN #3. The physician for Resident #5 was notified on July 17, 2012 by a licensed nurse.</p> <p>The Administrator was approached by the Social Service Assistant (SSA) on July 9, 2012 and expressed concern about a conversation occurring between Resident #1 and the Director of Nursing (DON). The SSA did not say anything about the conversation being verbally abusive at this time. The DON came to the administrator later in the day to discuss the conversation that the DON had with Resident #1. The administrator did not feel the conversation was abusive; therefore, no investigation in the situation was initiated.</p> <p>2. All Residents in the facility were assessed by facility licensed staff on August 8 & 9, 2012. The assessment tool that was used addressed; pattern</p>		



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F 223	<p>Continued From page 2</p> <p>returned to work. She reported the next day the Administrator called her and asked her to write a statement. CNA #5 stated she did not have an answer as to why she waited two days to report the incident. She realized now that she should have reported it immediately. She stated there was another nurse on duty the night of the incident that she could have reported the incident to.</p> <p>Interview with LPN #3, on 07/16/12 at 11:53 AM, revealed his account of the incident was similar to the CNA's except all his movements were defensive to protect both the resident and himself. He was trying to calm the resident down. However, he denied any physical abuse to Resident #5.</p> <p>Interview with the Administrator, on 07/16/12 at 2:46 PM, revealed she called LPN #3 and he denied abuse toward Resident #5. She stated she examined the resident and found no signs of abuse. She stated that to her knowledge a nurse did not examine the resident for injuries. There was no documentation that the resident's physician was notified. The Administrator stated when she interviewed LPN #4 and she reported no other incidents of resident abuse. When asked if it takes more than one incident to be considered abuse the administrator responded no. The Administrator stated she felt like she had investigated the allegation.</p> <p>Interview with the Social Services Director (SSD), on 07/16/12 at 3:33 PM, revealed the role of the SSD in alleged abuse was to do an investigation which involved interviewing the resident, find out who was working and get interviews or</p>	F 223	<p>areas of contusions or reddened areas, any bruising to the arms, legs or torso area. Each resident was also asked if they were comfortable living in the facility as they were assessed to initiate dialogue from the resident's in cases where the resident felt uncomfortable in the facility. No residents were identified to show evidence of abuse, punishment or seclusion.</p> <p>3. The facility will put into place the following systemic changes to ensure the alleged deficient practice does not occur in the future. On July 30, 2012 and August 20, 2012 the Administrator and DON reviewed the Abuse Policies and Procedures for the facility and made updates and changes to the policies. The facilities updated abuse policy is attached as Attachment A. On August 1, 2012 the Director of Nursing (DON), Social Service</p>	



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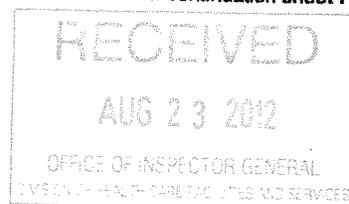
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F 223	<p>Continued From page 3</p> <p>statements from those staff. The State Agency and the Department for Community Based Services (DCBS) would be notified after an allegation was made. With that information the Administrator and the DON would finish interviewing and investigating and then send in a final investigation report to the State Agency and DCBS. The SSD stated she would make a note in the chart. She did not make a note in Resident #5's clinical record because the administrator stated she didn't think it was abuse and she would take care of it. During the course of a normal investigation she would make sure that the resident was safe and not in emotional distress, she would check on the resident for a couple of days to make sure they were okay and that information was charted. She also would talk to the family to make sure they did not have any concerns or if they did she would follow up.</p> <p>2) Review of the clinical record revealed the facility admitted Resident #1 on 03/03/10 with diagnoses of Senile Dementia with Behaviors, Anxiety and Depression. The facility assessed the resident on the Minimus Data Set (MDS), dated 05/28/12, with a cognitive score of six (6) meaning the resident had severe cognitive impairment.</p> <p>Interview with Social Services Assistant (SSA), on 07/12/12 at 12:19 PM, revealed she was in Resident #1's room while the Director or Nursing (DON) was speaking to the resident about aggressive behavior the resident had exhibited when she felt the DON became verbally abusive. The SSA stated the DON told the resident that if the behaviors continued the facility would have to send him/her back to a hospital for psychiatric</p>	F 223	<p>Director (SSD), Assistant Directors of Nursing (ADONs), Week-end Supervisor and Staffing Coordinator were inserviced on the policy and procedures of how to report abuse to the Administrator immediately. The DON, SSD, ADONs, Week-end Supervisor and Staffing Coordinator were given the revised "First Report of Abuse" tool and inserviced on how to utilize the tool. The "First Report of Abuse" tool assures that the Office of Inspector General, Adult Protective Services, Ombudsman, and police department (if necessary) are notified. By August 6, 2012 all licensed nurses were inserviced by the DON, one of the two ADONs or the Week-end Nurse Supervisor regarding the process of reporting allegations of abuse to the Administrator immediately, and how to report</p>	
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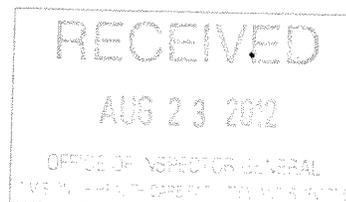
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F 223	<p>Continued From page 4</p> <p>treatment and he/she would not be allowed back in the facility. The DON then told the resident that two previous facilities the resident had resided in would not take him/her back and his/her family wouldn't have any place to send him/her. The SSA stated she felt this was verbal abuse as it was loud and disrespectful to the resident. The SSA stated she called and reported the incident to her supervisor, the Social Services Director (SSD) and talked to the Administrator about the incident.</p> <p>Interview with the Director of Nursing (DON), on 07/12/12 at 2:20 PM, revealed she was speaking in a very declarative language. When she started talking to Resident #1, the resident started yelling at her. She told the resident he/she could not spit, hit, shove, push, or slap other residents. She told the resident there was no place else for him/her to go to now, that Wellstone (In-patient psychiatric hospital) would not take her back. The previous nursing home would not take him/her back as well and they needed to find a way for the resident to stay at this facility.</p> <p>Interview with the Social Services Director (SSD), on 07/12/12 at 5:15 PM, revealed she received a call on 07/09/12 from the Social Services Assistant (SSA). The SSA told her that Resident #1 had pushed another resident and the Director of Nursing (DON) was yelling at Resident #1. She stated she did not have all the facts and she instructed the SSA to report the information to the Administrator.</p> <p>Interview with the Administrator, on 07/12/12 at 4:16 PM, revealed the SSA had reported the incident to her on 07/09/12 but she did not feel</p>	F 223	<p>allegations of abuse to the Office of Inspector General, Adult Protective Services and Ombudsman by using the "First Report of Abuse" tool. On August 8, 2012 the Administrator was inserviced by the Director of Operations on the importance of reporting suspicions of abuse to the Office of Inspector General, Adult Protective Services and local law enforcement. On August 8, 2012 the Administrator was also inserviced by the Director of Operations on how to conduct an abuse investigation. On August 9, 2012 the DON and SSD were inserviced by the Administrator the importance of investigation each allegation abuse by conducting interviews and the importance of instructing staff to start a "First Report of Abuse" tool. The DON and SSD were inserviced on August 9, 2012 by the Administrator that if</p>	
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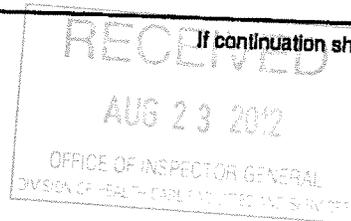
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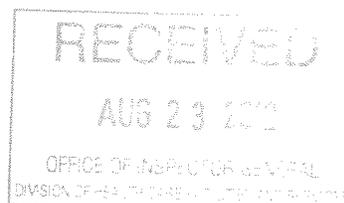
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F 223 F 225 SS=E	<p>Continued From page 5 she was reporting verbal abuse and she did not investigate it as verbal abuse.</p> <p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified</p>	F 223 F 225	<p>he/she is unavailable that the DON and SSD will immediately initiate an abuse investigation.</p> <p>August 17, 2012 the administrator conducted an all staff in-service on the following topics; the revised facility abuse policy, the types of abuse, that intimidation and threats are abuse, what to do if the alleged perpetrator was the Administrator or Director of Nursing, how to report the</p>	



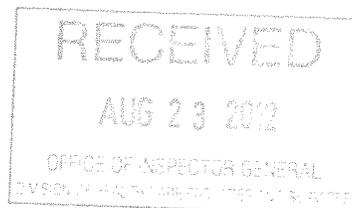
Administrator or DON of alleged abuse, to report suspensions of abuse to their supervisor immediately, and how to prevent abuse from occurring.

CNA #5 was inserviced by the administrator on August 9, 2012 about promptly reporting anything he/she felt was abusive to a resident immediately to a supervisor. The DON was also re-educated on August 9, 2012 by the administrator on how people differently interpret the tone of voice used with the residents. On August 9, 2012 the SSD was re-educated that during an abuse investigation she is to assist the administrator in investigation the alleged abuse. The SSD was also re-educated on the importance of making an entry into the resident medical record regarding the alleged abuse investigation.

4. The Administrator will inform the Director of Operations that an allegation of abuse has been made and that an abuse investigation has been started. The Administrator will send the Director of Operations the first report of abuse at the same time the first report of abuse is sent the Office of Inspector General, Adult



Protective Services and Ombudsman. Daily during the investigation, the Administrator will inform the Director of Operations the steps and progress of the abuse investigation. This will allow the Director of Operations to ensure that the facility policy and Plan of Correction are being followed. Internally the Quality Assurance Nurse will be notified by the Administrator within 24 hours of the first report of suspected abuse that an investigation is underway. The Quality Assurance Nurse will do a 24 hour audit to ensure that the facility abuse policy and Plan of Correction are being followed. Any areas of concern will be reported to the Administrator and Director of Operations. After the investigation is complete the Quality Assurance Nurse will conduct a post investigation audit to ensure the facility abuse policy and Plan of Correction was followed throughout the investigation. The findings of the report will be submitted to the Director of Operations. Monthly the Quality Assurance Nurse will submit a report of the post investigation audits to the Quality Assurance Team.

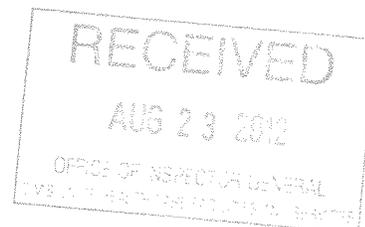


5. Date of completion: August 21, 2012

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F 225	<p>Continued From page 6 appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to protect residents from harm during abuse investigations for two (2) of five (5) sampled residents and three (3) unsampled residents. The facility allowed staff accused of abuse to continue to work in resident care areas after allegations of abuse had been levied against them.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Protection of Residents During Abuse Investigations, revealed employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended until the findings of the investigation have been reviewed by the Administrator.</p> <p>1) Review of the clinical record revealed the facility admitted Resident #5 on 08/01/09 with diagnoses of Dementia and Immobilization Syndrome. The facility assessed the resident on the Minimum Data Set (MDS), dated 05/22/12, with a cognition score of five (5) meaning the resident had severe cognitive impairment.</p> <p>Interview with CNA #5, on 07/16/12 at 2:24 PM, revealed she was working with LPN #3 on 07/09/12 when he became rough with Resident #5. She stated he treated the resident roughly</p>	F 225	<p>F-225</p> <p>1. The facility was not made aware of the allegation against LPN #3 until July 11, 2012 at 1:00 a.m. LPN #3 denied any abusive situation with Resident #5. LPN #3 stated that he/she was only trying to provide safety for the resident and himself. Resident #5 was assessed by the nursing staff on by nursing staff on July 11, 2012 at 1:15 a.m. by LPN #4 and no reddened or bruised areas were noted. Resident #5 did not remember the incident with LPN #3. The physician for Resident #5 was notified on July 17, 2012 by a licensed nurse.</p> <p>The Administrator was approached by the Social Service Assistant (SSA) on July 9, 2012 and expressed concern about a conversation occurring between Resident #1 and the Director of Nursing</p>	



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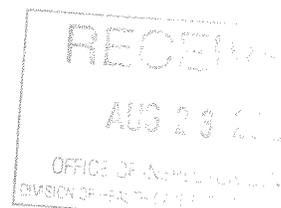
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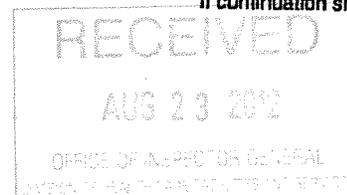
F 225	<p>Continued From page 7</p> <p>when trying to get him/her back in the bed by throwing her legs over the edge of the bed and then when the resident became upset over that he/she swung at LPN #3. She stated that as the resident took a swing at LPN #3, he grabbed and put both of the residents arms across his/her chest and told him/her to stop. CNA #5 stated the resident swung at LPN #3 again and this time LPN #3 hit him/her on the arm, but not too hard. The resident then told LPN #3 that he/she was going to get his/her Daddy to come up there and LPN #3 responded to the resident by saying bring it. CNA #5 stated she reported the incident to her supervisor on 07/11/12 when the supervisor returned to work. She reported the next day the Administrator called her and asked her to write a statement.</p> <p>Interview with LPN #4, on 07/16/12 at 3:45 PM, revealed that on 07/11/12, when she reported for her night shift, she was approached by two CNAs who alleged LPN #3 had physically abused Resident #5 over the weekend. They stated LPN #3 had been rough with a resident physically and told the resident to bring it on when the resident said he/she would call his/her Daddy. LPN #4 stated she immediately called the Administrator, about 1:00 AM on 07/11/12 and reported the events to her. The Administrator told her she would take care of the situation and that LPN #4 did not have to do anything else. She stated she was surprised that LPN #3 worked on the next night, 07/12/12, since there had been an allegation of abuse. She said that she complained to the scheduler about the situation and then on 07/13/12 when LPN #3 reported to work he was sent home until Monday, 07/16/12. LPN #4 stated CNA #5 had written up a report</p>	F 225	<p>(DON). The SSA did not say anything about the conversation being verbally abusive at this time. The DON came to the administrator later in the day to discuss the conversation that the DON had with Resident #1. The administrator did not feel the conversation was abusive; therefore, no investigation in the situation was initiated.</p> <p>2. All Residents in the facility were assessed by facility licensed staff on August 8 & 9, 2012. The assessment tool that was used addressed; pattern areas of contusions or reddened areas, any bruising to the arms, legs or torso area. Each resident was also asked if they were comfortable living in the facility as they were assessed to initiate dialogue from the resident's in cases where the resident felt uncomfortable in the facility. No residents were identified to show evidence of abuse, punishment or seclusion.</p>	
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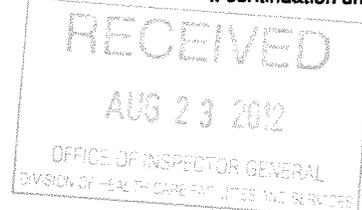
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2012
NAME OF PROVIDER OR SUPPLIER THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(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	<p>Continued From page 8 alleging abuse by LPN #3 and that report was given to the Administrator.</p> <p>Interview with the Administrator, on 07/16/12 at 2:46 PM, revealed she had received a call, at 1:00 AM on 07/11/12, from LPN #4 alleging abuse by LPN #3 as reported by CNA #5. She stated she called LPN #3 and he denied the allegation. She stated she had so many written notes by staff lately on different matters that she could not remember if she had been given a note written by CNA #5 or not. She stated she was unable to locate a written account of the allegation by CNA #5.</p> <p>2) Review of the clinical record revealed the facility admitted Resident #1 on 03/03/10 with diagnoses of Senile Dementia with Behaviors, Anxiety and Depression. The facility assessed the resident on the Minlmum Data Set (MDS), dated 05/28/12, with a cognitive score of six (6) meaning the resident had severe cognitive impairment.</p> <p>Interview with the Social Services Assistant (SSA), on 07/12/12 at 12:19 PM, revealed she was in Resident #1's room while the Director or Nursing (DON) was speaking to the resident about aggressive behavior when she felt the DON became verbally abusive. The SSA stated the DON told the resident that if the behaviors continued the facility would have to send him/her back to a hospital for psychiatric treatment and he/she would not be allowed back in the facility. The DON then told the resident that two previous facilities would not take him/her back and his/her family wouldn't have any place to send him/her. The SSA stated she felt this was verbal abuse as</p>	F 225	<p>3. The facility will put into place the following systemic changes to ensure the alleged deficient practice does not occur in the future. On July 30, 2012 and again on August 20, 2012 the Administrator and DON reviewed the Abuse Policies and Procedures for the facility and made updates and changes to the policies. The facility abuse policy is attached as Attachment A. On August 1, 2012 the DON, SSD, ADONs, Week-end Supervisor and Staffing Coordinator were inserviced by the Administrator on the policy and procedures of how to report abuse to the Administrator immediately and how to use the "First Report of Abuse" tool. The "First Report of Abuse" tool assures that the Office of Inspector General, Adult Protective Services and Ombudsman are notified. By August 6, 2012 all licensed nurses were</p>	



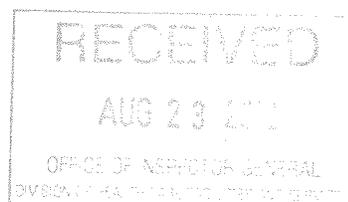
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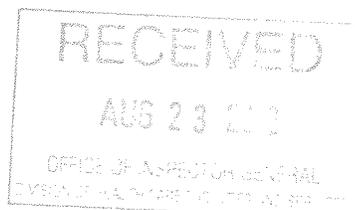
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F 225	Continued From page 9 it was loud and disrespectful to the resident. The SSA stated she called and reported the incident to her supervisor, the Social Services Director (SSD) and talked to the Administrator about the incident. Interview with the Administrator, on 07/12/12 at 4:16 PM, revealed the SSA talked to her about the incident. The SSA reported to her that the DON had talked loudly to the resident but never said she had yelled at the resident. The SSA told the Administrator that CNAs would never be allowed to talk to a resident the way the DON had spoken to the resident. The Administrator said she told the SSA that the DON needed to address the issues and CNAs should not be. The Administrator stated that she did not feel the SSA was reporting abuse to her. She thought she just had questions about what was said. She stated she did not investigate it as an allegation of abuse and the DON was not kept from patient contact. She stated the SSD spoke with her on 07/11/12, and told her that someone from the facility had called the State Agency about the incident.	F 225	inserviced by the DON, one of the two ADONs or the Weekend Nurse Supervisor regarding the process of reporting allegations of abuse to the Administrator immediately, and how to report allegations of abuse to the Office of Inspector General, Adult Protective Services and Ombudsman by utilizing the "First Report of Abuse" tool. On August 8, 2012 the Administrator was inserviced by the Director of Operations on the importance of reporting suspicions of abuse to the Office of Inspector General, Adult Protective Services and local law enforcement. On August 8, 2012 the Administrator was also inserviced by the Director of Operations on how to conduct an abuse investigation. On August 9, 2012 the DON and SSD were inserviced by the Administrator the importance	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based upon interview, record review and review of the facility's Abuse policy, it was determined the facility failed to implement their abuse policy	F 226		



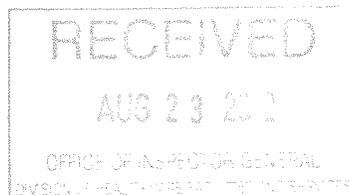
of investigation each allegation abuse by conducting interviews and the importance of instructing staff to start a "First Report of Abuse" tool. The DON and SSD were inserviced on August 9, 2012 by the Administrator that if he/she is unavailable that the DON and SSD will initiate an abuse investigation. CNA #5 was inserviced by the administrator on August 9, 2012 about promptly reporting anything he/she felt was abusive to a resident immediately to a supervisor. The DON was also re-educated on August 9, 2012 by the administrator on how people differently interpret the tone of voice used with the residents. On August 9, 2012 the SSD was re-educated that during an abuse investigation she is to assist the administrator in investigation the alleged abuse. The SSD was also re-educated on the importance of making an entry into the resident medical record regarding the alleged abuse investigation. . August 17, 2012 the administrator conducted an all staff in-service on the following topics; the revised facility abuse policy, the types of abuse, that intimidation and threats are abuse, what to do if the alleged perpetrator was the



Administrator or Director of Nursing, how to report the Administrator or DON of alleged abuse, to report suspensions of abuse to their supervisor immediately, and how to prevent abuse from occurring. Also during the all staff in-service conducted on August 17, 2012 by the Administrator staff were informed of the following information. When an allegation of suspected abuse is made by a staff member, family member, resident, visitor, or practitioner, and the accused is a staff member that individual will be removed from resident service. At that time the Administrator will also notify the DON, and SSD. The DON will ensure that the accused staff member has been removed from resident care areas. During the investigation the DON will ensure that an accused staff member does not return to resident areas while the Administrator conducts the investigation. If the staff member is found to have not committed resident abuse the staff member will be allowed to return to work in resident areas. If the accused staff member is found to be guilty of abuse the staff member will be terminated from employment with the facility,

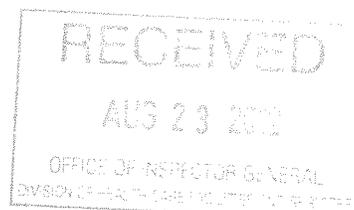


and reported to appropriate licensing agencies. If the person accused in the abuse allegation is a resident the following will occur. The accused resident will have an incident report completed, and a progress note entered into the medical chart by a licensed nurse. The accused residents family/representative will be notified as will their physician or physician extender will be notified of the allegation. If the allegation is any reasonable suspicion of a crime the police department will also be notified by the Administrator. The accused resident will be put on one on one observation. The observation will be done by a facility staff member. During the investigation the accused resident will not be allowed to enter resident common areas in order to ensure the safety of the other residents in the facility. The accused resident will remain under one on one observation until the conclusion of the Administrators investigation. After the investigation is complete and no abuse was found to have occurred the accused resident will be removed from one on one observation, and assessed by the SSD for any psychosocial needs related to being on one



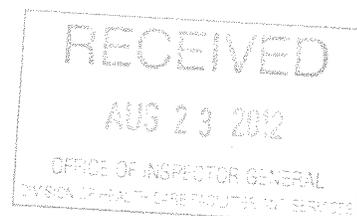
on one observation. If it is found that abuse did occur by the accused resident the accused resident will be assessed for their individual need.

4. The Administrator will inform the Director of Operations that an allegation of abuse has been made and that an abuse investigation has been started. The Administrator will send the Director of Operations the first report of abuse at the same time the first report of abuse is sent to the Office of Inspector General, Adult Protective Services and Ombudsman. Daily, during the investigation, the Administrator will inform the Director of Operations the steps and progress of the abuse investigation. This will allow the Director of Operations to ensure that the facility policy and Plan of Correction are being followed. Internally the Quality Assurance Nurse will be notified by the Administrator within 24 hours of the first report of suspected abuse that an investigation is underway. The Quality Assurance Nurse will do a 24 hour audit to ensure that the facility abuse policy and Plan of Correction are being followed. Any areas of



concern will be reported to the Administrator and Director of Operations. After the investigation is complete the Quality Assurance Nurse will conduct a post investigation audit to ensure the facility abuse policy and Plan of Correction was followed throughout the investigation. The findings of the report will be submitted to the Director of Operations. Monthly the Quality Assurance Nurse will submit a report of the post investigation audits to the Quality Assurance Team.

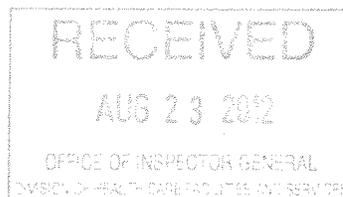
5. Date of completion: August 21, 2012



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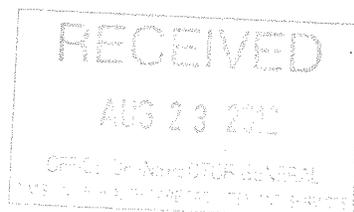
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2012
NAME OF PROVIDER OR SUPPLIER THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
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F 226	<p>Continued From page 10</p> <p>by failing to report three (3) allegations of resident abuse involving 2 (two) of five (5) sampled residents and three (3) unsampled residents, Residents #1 and #5.</p> <p>The findings include:</p> <p>Review of the facility's Abuse policy revealed all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law.</p> <p>1) Review of the clinical record revealed the facility admitted Resident #1 on 03/03/10 with diagnoses of Senile Dementia with Behaviors, Anxiety and Depression. The facility assessed the resident on the Minimum Data Set (MDS), dated 05/28/12, with a cognitive score of six (6) meaning the resident had severe cognitive impairment.</p> <p>Review of Resident #1's clinical record revealed on 05/20/12 there was an altercation between Resident #1 and another resident. The second resident bumped Resident #1's wheelchair and Resident #1 started hitting the resident with fists, striking the second resident two to three times in the right arm and shoulder. The residents were separated and assessed. Every fifteen minute checks were initiated on Resident #1. The house supervisor and Social Services Director were notified and messages were left for the Administrator and Director of Nursing (DON). A referral was made to a local psychiatric hospital for evaluation but was not accepted for admission at that time. On 06/27/12 it was noted in the clinical record Resident #1 was aggressive</p>	F 226	<p>F-226</p> <p>1. The facility was not made aware of the allegation against LPN #3 until July 11, 2012 at 1:00 a.m. LPN #3 denied any abusive situation with Resident #5. LPN #3 stated that he/she was only trying to provide safety for the resident and himself. Resident #5 was assessed by the nursing staff on by nursing staff on July 11, 2012 at 1:15 a.m. by a LPN #4 and no reddened or bruised areas were noted. Resident #5 did not remember the incident with LPN #3. The physician for Resident #5 was notified on July 17, 2012 by a licensed nurse. The Administrator was approached by the Social Service Assistant (SSA) on July 9, 2012 and expressed concern about a conversation occurring between Resident #1 and the Director of Nursing (DON). The SSA did not say anything about the conversation being verbally</p>		



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F 226	<p>Continued From page 12</p> <p>Interview with the Administrator, on 07/12/12 at 11:02 AM, revealed she thought the State Agency was here to investigate this allegation because a disgruntled employee had called in an allegation.</p> <p>Interview with the Administrator, on 07/12/12 at 4:16 PM, revealed the SSA had come to her on 07/09/12 and reported that the DON had spoken loudly to Resident #1. She stated the SSA had reported the DON stated the resident needed to behave, that there was no other facility that would take her. The Administrator did not feel the SSA was alleging abuse so there was nothing to investigate or report.</p> <p>3) Review of the clinical record revealed the facility admitted Resident #5 on 08/01/09 with diagnoses of Dementia and Immobilization Syndrome. The facility assessed the resident on the Minimum Data Set (MDS), dated 05/22/12, with a cognition score of five (5) meaning the resident had severe cognitive impairment.</p> <p>Interview with CNA #5, on 07/16/12 at 2:24 PM, revealed she was working with LPN #3 on 07/09/12 when he became rough with Resident #5. She stated he treated the resident roughly when trying to get him/her back in the bed by throwing his/her legs over the edge of the bed and then when the resident became upset over that he/she swung at LPN #3. She stated as the resident took a swing at LPN #3, he grabbed and put both of the residents arms across his/her chest and told him/her to stop. CNA #5 stated the resident swung at LPN #3 again and this time LPN #3 hit him/her on the arm, but not too hard. The resident then told LPN #3 that he/she was</p>	F 226	<p>the arms, legs or torso area. Each resident was also asked if they were comfortable living in the facility as they were assessed to initiate dialogue from the resident's in cases where the resident felt uncomfortable in the facility. No residents were identified to show evidence of abuse, punishment or seclusion.</p> <p>3. The facility will put into place the following systemic changes to ensure the alleged deficient practice does not occur in the future. On July 30, 2012 and August 20, 2012 the Administrator and DON reviewed the Abuse Policies and Procedures for the facility and made updates and changes to the policies. The facility abuse policy is attached as Attachment A. On August 1, 2012 the DON, SSD, ADONs, Week-end Supervisor and Staffing Coordinator were</p>		



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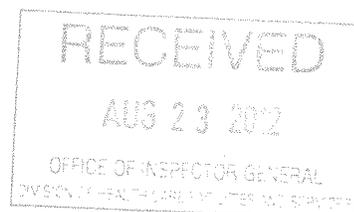
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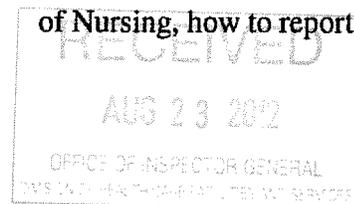
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F 226	<p>Continued From page 13</p> <p>going to get hisher Daddy to come up there and LPN #3 responded to the resident by saying bring it. CNA #5 stated she reported the incident to her supervisor on 07/11/12 when the supervisor returned to work. She reported the next day the Administrator called her and asked her to write a statement.</p> <p>Interview with the Social Services Director (SSD), on 07/16/12 at 3:33 PM, revealed she had been notified by the Administrator of the allegation of abuse against Resident #5. The SSD stated that normally during an investigation of alleged abuse she was involved in interviewing the resident and any staff who might have been involved. She said that the State Agency and Department of Community Based Services (DCBS) would be notified after an allegation was made. She would make a note in the clinical record and monitor the resident for any emotional distress. The Administrator and DON would then finish the investigation and send in the final report to the State Agency and DCBS. She stated the administrator told her she was handling the investigation and not to worry about anything, therefore no follow-up was done by the SSD on the allegation.</p> <p>Interview with the Administrator, on 7/16/12 at 2:46 PM revealed she felt like she investigated the allegation and felt the staff were just trying to retaliate against LPN #3 for another matter and that is why she did not report the incident to the DCBS or to the State Agency as outlined in the abuse policy.</p>	F 226	<p>inserviced on the policy and procedures of how to report abuse to the Administrator immediately. The DON, SSD, ADONs, Week-end Supervisor and Staffing Coordinator were given the revised "First Report of Abuse" tool and inserviced on how to utilize the tool. The tool assures that the Office of Inspector General, Adult Protective Services and Ombudsman are notified. By August 6, 2012 all licensed nurses were inserviced by the DON, one of the two ADONs or the Week-end Nurse Supervisor regarding the process of reporting allegations of abuse to the Administrator immediately, and how to report allegations of abuse to the Office of Inspector General, Adult Protective Services and Ombudsman by using the "First Report of Abuse" tool.</p>	
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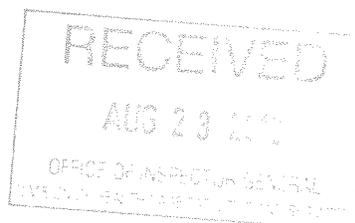


On August 8, 2012 the Administrator was inserviced by the Director of Operations on the importance of reporting suspicions of abuse to the Office of Inspector General, Adult Protective Services and local law enforcement. On August 8, 2012 the Administrator was also inserviced by the Director of Operations on how to conduct an abuse investigation. On August 9, 2012 the DON and SSD were inserviced by the Administrator the importance of investigation each allegation abuse by conducting interviews and the importance of instructing staff to start a "First Report of Abuse" tool. The DON and SSD were inserviced on August 9, 2012 by the Administrator that if he/she is unavailable that the DON and SSD have the authority to initiate an abuse investigation. August 17, 2012 the administrator conducted an all staff in-service on the following topics; the revised facility abuse policy, the types of abuse, that intimidation and threats are abuse, what to do if the alleged perpetrator was the Administrator or Director of Nursing, how to report the



Administrator or DON of alleged abuse, to report suspensions of abuse to their supervisor immediately, and how to prevent abuse from occurring.

4. The Administrator will inform the Director of Operations that an allegation of abuse has been made and that an abuse investigation has been started. The Administrator will send the Director of Operations the first report of abuse at the same time the first report of abuse is sent the Office of Inspector General, Adult Protective Services and Ombudsman. Daily during the investigation the Administrator will inform the Director of Operations the steps and progress of the abuse investigation. This will allow the Director of Operations to ensure that the facility policy and Plan of Correction are being followed. Internally the Quality Assurance Nurse will be notified by the Administrator within 24 hours of the first report of suspected abuse that an investigation is underway. The Quality Assurance Nurse will do a 24 hour audit to ensure that the facility abuse



policy and Plan of Correction are being followed. Any areas of concern will be reported to the Administrator and Director of Operations. After the investigation is complete the Quality Assurance Nurse will conduct a post investigation audit to ensure the facility abuse policy and Plan of Correction was followed throughout the investigation. The findings of the report will be submitted to the Director of Operations. Monthly the Quality Assurance Nurse will submit a report of the post investigation audits to the Quality Assurance Team.

5. Date of completion:
August 21, 2012

