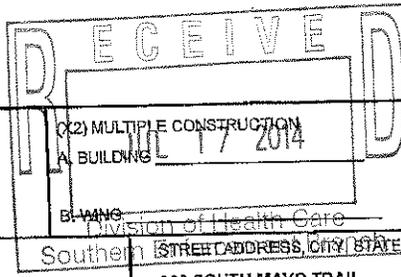


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 17 2014 B. WING Division of Health Care	(X3) DATE SURVEY COMPLETED R-C 06/04/2014
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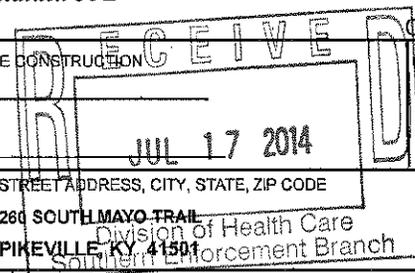
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501
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		F-000	<p>SHC of Pikeville takes all allegations of abuse very seriously. It has a robust policy upon which all staff have been educated, and will continue to be re-educated, as needed from time to time and on a regular basis to continually validate staff understanding of same. Pikeville staff understands that it must serve as an abuse advocate at all times for each and every resident we serve, and when abuse of any kind (e.g., physical or verbal abuse or neglect, or misappropriation of resident property) is suspected, heard, seen, or alleged by any staff member, resident, or family member, (i) to immediately protect the resident by ensuring the resident's safety (this will include the removal of the alleged perpetrator from all care areas and if an employee, suspending him/her), and (ii) to immediately take appropriate reporting action upon seeing the abusive conduct or hearing the abuse allegation. All suspicions and allegations of abuse will be reported to OIG, APS and Ombudsmen immediately, as well as other authorities as required by state law and/or as appropriate. The facility will also initiate a thorough investigation and impose appropriate discipline, as warranted.</p> <p>As outlined further below, recent training to all staff on Pikeville's abuse policy and procedure was performed and included examples of items that are state reportable: (i) any report of staff, family, or other persons being physically or verbally mean, rough, or threatening towards a resident, as well as any other statements of any kind indicating or describing such conduct -- regardless of whether such conduct may be re-defined, interpreted, or clarified by a resident as not meant to be intentional or abusive, injuries of unknown origin, withholding or taking of resident belongings, (ii) resident to resident altercations (verbal or physical), (iii) misappropriation, and/or (iv) any other resident exploitation of any kind. It also made clear that allegations of abuse are NOT to be handled, reported, or processed through the facility's grievance system ever; all must be processed and reported to the state as outlined above. Finally, all department heads will be trained on how to conduct a thorough investigation and substantiate abuse, where warranted.</p>	

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Amended *SCD*

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501 Division of Health Care Southern Enforcement Branch
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{F 000}	<p>INITIAL COMMENTS</p> <p>--Amended--</p> <p>An on-site revisit for the standard survey was initiated on 05/28/14 in conjunction with an abbreviated standard survey (KY21748). As a result of this visit, deficient practice cited at 42 CFR 483.13 Resident Behavior and Facility Practices (F225) and 42 CFR 483.75 Administration (F520) was not corrected.</p> <p>The complaint (KY21748) was substantiated. Immediate Jeopardy was identified on 05/29/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520) with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). Immediate Jeopardy was determined to exist on 05/24/14 and the facility was notified of the Immediate Jeopardy on 05/29/14.</p> <p>Interviews and review of witness statements revealed on 05/23/14, Resident #35 reported that State Registered Nurse Aide (SRNA) #3 talked mean to him/her when the resident had requested a cold, wet washcloth. Even though the facility identified the alleged perpetrator in the incident related to Resident #35 as SRNA #3, the facility allowed SRNA #3 to continue to provide care to other residents in the facility.</p> <p>In addition, review of incident reports and interviews revealed on 05/25/14, staff observed bruising to Resident #32's arm. The resident reported "fat Pat grabbed" his/her arm. The facility identified the alleged perpetrator as SRNA</p>	{F 000}	<p>F-520-225</p> <ol style="list-style-type: none"> The allegation of abuse reported by residents # 32 and 35 were reported to the Office of Inspector General by 5/29/14 by the Director of Nursing and reported to APS, Ombudsman, MD and POA by 5/30/14 by the Director of Nursing, ADON or charge nurse. Resident # 32 and 35 have been physically assessed by a nurse and psychosocially assessed by the social services director by 5/30/14. Resident # 32 and 35 were interviewed and statement obtained by the house supervisor, director of nursing or social services director by 5/30/14. Alleged perpetrator for resident # 32 was suspended pending outcome of thorough investigation and alleged perpetrator for resident #35 is no longer employed by the facility. Thorough investigation initiated on residents #32, and 35 by 5/30/14 by the DON, ADONS, Social services director or regional nurse consultant. All residents have been assessed for any signs and symptoms of abuse/neglect. Those residents with BIMs >8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 5/29/14. Those residents with BIMs < 8 were physically assessed by the ADONS for any signs and symptoms of abuse/neglect along with all resident POA's contacted by social services director or chaplain to question any abuse/neglect concerns by 6/1/14. An audit of all personnel records, to include any counseling, coaching, suspension and/or termination forms, was completed by the Human Resources Director and results reviewed by the Chief Nursing Executive by 5/30/14, to ensure compliance with federal and state regulations related to reporting any suspected abuse/neglect allegations and the employment of staff. 	6/30/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shawn O'Conner by Eddy Starbuck</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/17/14</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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{F 000}	Continued From page 1 #2. Interviews revealed SRNA #2 was suspended on 05/25/14 while the DON investigated the incident, and was allowed to return to work on 05/26/14 after the DON stated she did not feel "like it was an allegation of abuse" because the resident reported different stories about the incident. The facility's Administration failed to ensure allegations of abuse and neglect were reported immediately to appropriate State Agencies and failed to ensure residents were protected from potential abuse while an investigation of the alleged abuse was conducted. In addition, the facility's Administration also failed to ensure the facility's investigation included resident and staff interviews and an assessment of other residents for signs of abuse and neglect. An acceptable Allegation of Compliance was received on 06/02/14 which alleged removal of the Immediate Jeopardy on 05/31/14. A partial extended survey was conducted on 06/03/14 through 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F225 and F226.)	{F 000}	A review of all grievances and accidents/incidents from January 2014 to May 2014 was completed by DON, ADONs' SDC, MDS, by 5/30/14 to ensure all have been thoroughly investigated along with any suspected abuse/neglect identified was reported in accordance with state/federal law to ensure reporting guidelines have been met. 1 allegation was identified, reported in accordance with state/federal guidelines and thorough investigation completed. All residents were assessed for any suspected and/or allegations of abuse/neglect. Residents with BIMs score of > 8 were interviewed by the Social services director or chaplain by 5/30/14 for any suspected neglect issues and Residents with BIMs score of < 8 were assessed by DON, ADONs, FPN, or SDC by 5/30/14 for any s/s of suspected neglect along with residents POA's were contacted and questioned by social services director or chaplain by 5/30/14 for any suspected abuse/neglect concerns. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator, Regional Nurse Consultant or the Chief Nurse Executive by 5/30/14 for any indications of abuse/neglect concerns. Chart audits to include review of nurses notes, dietary notes, social services notes, quality of life notes and interdisciplinary notes were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or Regional Nurse Consultant by 5/30/14 for all residents to identify any suspected abuse/neglect allegations that have not been reported.		
{F 225} SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	{F 225}	3. The facility department managers, to include, administrator, DON, ADONs, SDC, MDS, wound		

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{F 225}	<p>Continued From page 2</p> <p>mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's incident report, review of staff witness statements, and review of the facility's policy, it</p>	{F 225}	<p>care nurse, BOM, QOL, maintenance director, Housekeeping director, DM, Marketing/Admissions, SSD, RSM, FFN MR and Chaplain received education from the Regional Nurse Consultant on 5/29/14 regarding the abuse/neglect policy and procedure which included - appropriately identifying any suspected abuse/neglect allegations, appropriate reporting in accordance with state/federal guidelines, ensuring safety of the residents, and conducting a thorough investigation along with the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and question and include examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident to resident altercations to include verbal or physical, and taking belongings or exploitation. Post-test was administered and 100% score obtained, if manager did not score 100% on post-test, then manager will be immediately re-educated and post-test re-administered. This process will continue until manager obtains a 100% score on post-test.</p> <p>Once the facility Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN were re-educated on the abuse policy they were then assigned to re-educate the staff on the abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements, which started on 5/29/14. No employee will be allowed to work until abuse</p>	

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{F 225}	<p>Continued From page 3</p> <p>was determined the facility failed to ensure allegations of abuse and neglect were reported immediately to the facility's Administrator, the State Survey Agency, and other officials in accordance with State law for two (2) of three (3) sampled residents (Residents #32 and #35). The facility failed to ensure all allegations were investigated and failed to ensure residents were protected from further potential abuse during the facility's investigation.</p> <p>The facility documented on an incident report dated 05/25/14, that facility staff observed bruises to Resident #32's left wrist/forearm on 05/25/14. The resident informed staff on 05/25/14 that a nurse aide (identified by the facility as State Registered Nurse Aide #2) had "grabbed" his/her arm and "wouldn't let go." Review of the investigation revealed staff working at the time the resident's bruises were discovered was interviewed; however, other residents were not interviewed and the staff did not conduct skin assessments of other residents to determine if there were other bruises, and/or if there were other allegations of abuse until 05/28/14, three (3) days after the bruises on Resident #32's arm were observed. Further review of the investigation revealed the facility identified State Registered Nurse Aide (SRNA) #2 as the alleged perpetrator; the SRNA was suspended from resident care on 05/25/14 (the day staff observed the bruises on the resident's arm) but was allowed to return to work and provide direct resident care on 05/26/14 (two days prior to the assessments of other residents). Continued review of the investigation revealed the facility failed to notify the State Survey Agency of the allegation of abuse until 05/28/14 (three days after the bruises had been observed). The facility</p>	{F 225}	<p>education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. Education regarding the abuse policy and procedure, to include identification/reporting and the Quality Assurance Performance Improvement process will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until abuse education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test.</p> <p>Staff questionnaire regarding abuse, to include the question, "What would you do if a resident told you that you were mean to them", is being administered by Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN to 10 different staff members daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating and reporting of abuse/neglect, and the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plan. Results of the staff questionnaire will be reported to the QA committee weekly for 4 weeks, starting on 5/29/14, to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will</p>	

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{F 225}	<p>Continued From page 4</p> <p>failed to ensure staff acted in accordance with the facility's policy that indicated, "...All allegations of abuse will be investigated and reported to the appropriate agencies...The Administrator and/or DON will notify state agencies according to their reporting guidelines...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other official in accordance with State law through established guidelines."</p> <p>In addition, review of employee files revealed staff witness statements in SRNA #3's personnel file that alleged SRNA #3 had been verbally abusive to Resident #35. Review of a witness statement written on 05/24/14, by Licensed Practical Nurse (LPN) #2 revealed on 05/23/14, Resident #35 reported that SRNA #3 had talked mean to him/her when he/she requested a cold, wet washcloth. The facility failed to provide written documentation that staff conducted a thorough investigation. The facility's investigation did not include interviews with other residents or evidence that the allegations had been reported to the facility's Administrator and the State Survey Agency. The facility allowed SRNA #3 to provide direct resident care on 05/23/14 and 05/25/14 which was not in accordance with facility policy which stated, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation...", and that "...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State</p>	{F 225}	<p>determine at what frequency the staff questionnaire will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected Abuse/neglect was thoroughly investigated and completed along reporting guidelines are met.</p> <p>Hand in Hand training, module one, was initiated on 5/13/14 by SDC and completed on 6/4/14. There is an education calendar in which all modules have been scheduled to include all 6 modules over the next 6 months. Make up sessions will be offered until all employees have attended. New employees in orientation will receive the Hand in Hand training on a set schedule to ensure all 6 modules are completed.</p> <p>The Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN, will be on site daily for 4 weeks to perform walking rounds in which 10 residents (five with BIMs >8 and five with BIMs <8) will be visited by the department head and interviewed regarding staff treatment for those residents that can be interviewed and for those residents who are not able to be interviewed the department heads will visit the resident, skin check will be completed by nurse as well as speak to nurse and C.N.A. regarding any noted changes in resident behaviors. The facility department heads also will interview 10 different staff members daily regarding the types of abuse, who is the abuse coordinator, when is suspected abuse reported, what would you do if a resident told you that you were mean to them etc. which began on 5/29/14. Results of resident and staff</p>		

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{F 225}	<p>Continued From page 5 law through established guidelines..."</p> <p>The facility's failure to immediately report all allegations of abuse/neglect, failure to protect residents during the course of an investigation of abuse/neglect, and failure to investigate allegations of abuse/neglect caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/24/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520).</p> <p>An acceptable Allegation of Compliance was received on 06/02/14 which alleged removal of the Immediate Jeopardy on 05/31/14. A partial extended survey was conducted on 06/03/14 and 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F226.)</p> <p>The findings include:</p> <p>Review of the facility's policy, "Abuse, Neglect and Misappropriation," revised March 2013, revealed "...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines..." In addition, the policy revealed, "...The charge nurse will immediately</p>	{F 225}	<p>questionnaire's will be reported to the Administrator, DON, Regional Nurse Consultant or VP of Operations daily and if the Administrator is not in the facility the Department Director conducting the questionnaires will telephone the Administrator or VP of Operations the results of the resident and staff questionnaires.</p> <p>The Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN will notify Administrator of any concerns immediately regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect or misappropriation, ensuring resident is safe. A binder, which is passed on to each Department Head assigned to perform the resident and staff questionnaires daily, which contains a resident roster in which the interview date and shift is noted next to resident name to ensure that residents with BIMs >8 will be interviewed and residents with BIMs <8 will be visited, with skin checks completed, beginning on 5/29/14. The MDS Coordinators have the responsibility for updating the binder weekly to identify residents with BIMs >8 and residents with BIMs <8. If abuse, mistreatment, neglect or misappropriation is alleged during the interviews and or visits or reported by a staff member the Department Head will ensure the resident is safe, report to a charge nurse in which the charge nurse will remove the alleged perpetrator to a non-patient care area and notify the Administrator, Director of Nursing, and/or Social Services Direct/Abuse Coordinator. The alleged perpetrator will be suspended and a thorough investigation will begin immediately.</p>		

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{F 225}	<p>Continued From page 6</p> <p>remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..." The facility's policy also revealed, "...The charge nurse will immediately notify the Administrator, DON and/or Abuse Coordinator as appropriate...The Administrator and/or DON will notify state agencies according to their reporting guidelines...All allegations of abuse will be investigated and reported to the appropriate agencies...The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances..."</p> <p>1. Review of Resident #32's medical record revealed the facility admitted the resident on 12/06/13 with diagnoses which included Dementia, Alzheimer's Disease, Coronary Artery Disease, and Hypertension. Review of Resident #32's Minimum Data Set (MDS) Quarterly Assessment, dated 02/04/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident's cognition was moderately impaired.</p> <p>Review of an incident report, dated 05/25/14, revealed on 05/25/14, an SRNA called a nurse to Resident #32's room because she had observed two dark blue bruises on the resident's left wrist/forearm area. Continued review of the incident report revealed the resident stated, "Fat Pat grabbed my arm and wouldn't let it go; I had to pull myself loose."</p> <p>Interview was attempted with Resident #32 on 05/28/14 at 11:10 AM. However, the resident stated, "I don't want to talk about this [s***]"</p>	{F 225}	<p>The Administrator, Director of Nursing, Social Services or a member of regional staff will review all resident and staff questionnaires daily for any grievances/concerns and/or suspected allegations of abuse/neglect. Any suspected allegations of abuse/neglect will be immediately reported in accordance with state/federal guidelines and thorough investigations of any suspected allegations of abuse/neglect along with any grievances/concerns will be initiated upon receipt, starting on 5/30/14.</p> <p>During care plan conference for each resident any potential allegation of abuse/neglect will be discussed and education will be provided on whom to report abuse/neglect concerns by the MDS coordinator.</p> <p>The Administrator, Social Services Director or the Director of Nursing will review, daily, the grievances and incident/accident reports, starting 5/29/14, to determine if there are reportable allegations that have not been identified. Social Services Director or the Director of Nursing will report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect or misappropriation in accordance with state/federal guidelines to meet reporting requirements.</p> <p>An emergency resident council meeting was held on 5/30/14, Administrator and SDC attended, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. All residents with BIMS < 8 POA's were attempted to be contacted by Social Services Director to discuss any abuse/neglect concerns and to provide</p>	

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{F 225}	<p>Continued From page 7</p> <p>any more," and refused to provide any further information.</p> <p>Licensed Practical Nurse (LPN) #1 stated in interview conducted on 05/29/14 at 11:53 AM that she assessed Resident #32 when the bruises were identified by facility staff on 05/25/14. The LPN stated Resident #32 reported to her on 05/25/14 that "Fat Pat grabbed" his/her arm. LPN #1 identified the alleged perpetrator as SRNA #2. According to interview, LPN #1 stated she immediately notified the Director of Nursing (DON) on 05/25/14 of the resident's bruises and of Resident #32's allegation. The LPN stated the DON instructed staff to conduct a skin assessment of Resident #32, to obtain written statements from staff members that were present, and to immediately suspend the alleged perpetrator, SRNA #2. However, interview with LPN #1 revealed the DON failed to instruct her "to notify other officials in accordance with State law through established guidelines" as per the facility's policy.</p> <p>Interview with Registered Nurse (RN) #1 on 05/29/14 at 12:30 PM revealed she also assessed Resident #32 on 05/25/14, when the bruises were identified by facility staff. She further stated the alleged perpetrator had been identified, based on the resident's description, as SRNA #2. RN #1 stated she immediately notified the Administrator on 05/25/14 of the resident's bruises and the allegation of abuse. The RN further revealed the Administrator instructed her to follow the directions of the DON.</p> <p>Interview with the DON, on 05/28/14 at 4:30 PM, revealed she had been notified of the bruises to Resident #32's arm on 05/25/14 and that the</p>	{F 225}	<p>education on whom to report any abuse/neglect concerns without fear of retribution on 5/30/14.</p> <p>Nursing Administration (DON, ADON, Unit Manager, Staff Development Coordinator, MDS staff, facility formulary nurse, medical records, or social service director) will review documentation in the chart in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on 5 residents starting on 6/5/14. Any of the above concerns identified, the member of Nursing Administration will first ensure resident is safe by performing an assessment, notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area (if on duty) and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>Administrator will keep an abuse investigation log that will include documentation of the following: ensure resident is protected, report is filed timely, perpetrator is removed from patient care area and thorough investigation is completed. The Administrator will review the log daily as well as one of the following: Signature Care Consultant, VP of Operations, or Special Projects Administrator along with Chief Operating Officer or Chief Nursing Executive will review log for compliance weekly, starting on 6/5/14 for 4 weeks, then monthly.</p> <p>In the event of any new reports of alleged abuse, neglect or misappropriation of property, one of the following will be contacted within 24 hours and then again prior to making the final five day investigation report to OIG: Signature Care</p>		

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{F 225}	Continued From page 8 resident had alleged "fat Pat" had grabbed his/her arm. The DON stated she had instructed staff to assess Resident #32, to "gather statements from staff," and to tell the alleged perpetrator not to come to work that day (05/25/14) or until the incident had been "investigated." The DON stated staff had conducted an investigation of the alleged incident on 05/25/14. However, the DON acknowledged the facility had not assessed and/or interviewed other residents, including the residents that had received direct care by SRNA #2, for signs and/or reports of abuse during the investigation. The DON stated during the facility's investigation they had only interviewed staff that worked at the facility on the day the alleged incident was reported, and had only asked the staff about the alleged incident that occurred. In addition, the DON stated that based on the facility's investigation she "didn't think it was abuse because the resident had different stories about what had happened," had investigated the incident as an injury of unknown origin, and had not notified State Agencies of the incident. However, a review of the facility's policy revealed, "All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines." The DON further stated the alleged perpetrator (SRNA #2) was permitted to return to work on 05/26/14, the day after the alleged incident was reported. Interview with the Administrator on 05/29/14 at 6:17 PM revealed he was notified on 05/25/14 that Resident #32 had bruises on his/her arm and the resident had stated that "fat Pat grabbed" his/her arm. The Administrator stated he had not	{F 225}	Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator or Chief Nursing Executive) will insure the resident is protected, report is filed timely, the perpetrator is removed from the patient care area and a thorough investigation is initiated and completed. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive or Chief Operating Officer weekly starting 6/5/14 for 4 weeks, then monthly. DON, ADONs, or SDC will observe the care delivery, for any suspected abuse/neglect concerns on 1 resident/unit daily (Monday through Friday) starting on 6/5/14 for 4 weeks. Any concerns noted the nursing administration will first ensure resident is safe by performing an assessment and notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed. 4. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive, or Chief Operating Officer, weekly for 4 weeks beginning 6/5/14, then monthly.		

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{F 225}	<p>Continued From page 9</p> <p>considered the resident's statement as an allegation of abuse, but as an injury of unknown origin, because the resident had "told a lot of stories" as to how the bruises occurred when questioned by facility staff. However, based on the facility's policy, "The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances." Continued interview revealed the alleged perpetrator had been instructed not to come to work on the day the incident was reported (05/25/14) but had been allowed to return to work and provide direct resident care on 05/26/14. The Administrator acknowledged the facility had not included resident assessments and interviews in their investigation, and had not reported the resident's complaint to the State Agencies.</p> <p>2. Review of Resident #35's medical record revealed the facility admitted the resident on 04/29/14 with diagnoses which included Arthritis, Chronic Obstructive Pulmonary Disease, and Diabetes. Review of the Minimum Data Set admission assessment, dated 05/15/14, revealed the facility assessed Resident #35 to have a BIMS score of 11, which indicated the resident's cognition was moderately impaired.</p> <p>Interview with Resident #35 on 05/29/14 at 9:45 AM revealed the resident had asked SRNA #3 for a cold, wet washcloth for knee pain on 05/24/14 and the SRNA told the resident he didn't have insurance like the "rest of us." Continued interview revealed SRNA #3 brought the washcloth to the resident's room, threw the washcloth to the resident, and hit the resident's chest with the washcloth. Further interview revealed Resident #35 reported to nursing staff</p>	{F 225}	<p>The Administrator or Signature Care Consultant will audit compliance of the above stated audits/reviews daily (M-F). Results of the audits/reviews, which include, resident interviews, resident skin checks, staff questionnaires, grievance log review, A/I review, chart documentation audits and care delivery audits will be reported to the QA committee weekly x 4 weeks to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits/reviews, along with monitoring for compliance, will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected neglect was investigated and completed along with reporting guidelines are met.</p> <p>A follow-up questionnaire will be completed by the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 different staff members daily for 4 weeks beginning 6/5/14, to ensure continued understanding regarding the abuse/neglect policy, appropriate reporting, identification, and implementing care plans to meet resident care needs.</p> <p>A Quality Assurance meeting will be held weekly for 4 weeks beginning 5/28/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue.</p>		

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{F 225}	<p>Continued From page 10</p> <p>that SRNA #3 talked mean to him/her. Although the resident could not recall the exact date the incident occurred, the resident reported it all happened at the same time.</p> <p>Review of a witness statement written by LPN #2, on the night shift of 05/23/14 to 05/24/14, revealed on 05/24/14, between 3:00 AM and 4:00 AM, SRNA #3 was observed walking down the hall making statements that "I hate these people; I don't know what a washcloth's going to do for [him/her]." Continued review of the witness statement revealed on 05/24/14, Resident #35 called LPN #2 to his/her room to check the resident's blood sugar and she observed the resident crying. Further review of the witness statement revealed the resident reported, "That boy that was just in here talked mean to me." The witness statement further revealed Resident #35 had asked SRNA #3 for a cold, wet washcloth for knee pain and SRNA #3 made statements to the resident that the SRNA also had knee pain but did not have insurance to see a doctor like the residents and he didn't know what a washcloth was going to do to help. Continued review of the witness statement revealed the resident was very upset and did not want SRNA #3 in his/her room again. According to the witness statement, LPN #2 contacted the on-call nurse on 05/24/14 to report the incident and was instructed to switch SRNA #3 with an SRNA from the other hall and to contact the DON. The DON was contacted and she instructed LPN #2 to place the information about the incident on the 24 Hour Report Sheet and to keep SRNA #3 out of Resident #35's room. However, the facility's policy stated, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff</p>	{F 225}	The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.		

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

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

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

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

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

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

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

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{F 225}	Continued From page 18 told you that you were mean to them?" were administered by the Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff to five staff members on each shift and different staff members until immediacy was removed. After removal of immediacy, ten staff questionnaires were administered to staff daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating, and reporting of abuse/neglect. The questionnaire also included questions related to the QAPI process to include reporting of concerns to the Administrator and floor staff participation in development of the QAPI plan. Results of the staff questionnaire were reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of the plan. At that time, based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigation of suspected abuse/neglect was investigated/completed and reporting guidelines were met. -HR performed an audit of all personnel files for any abuse concerns on 05/29/14. Items that were reviewed: Coaching and Counseling forms, suspension forms, and termination forms. Results of the audit were given to the Chief Nursing Executive on 05/30/14, to review for any abuse/neglect concerns that needed reporting. There were no concerns identified.	{F 225}		

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{F 225}	<p>Continued From page 19</p> <p>--A nurse from the facility's regional team or corporate office had been on-site since 05/29/14 and remained in the facility daily until the jeopardy was removed. The nurses from the regional team or home office assisted with investigations, observed staff treatment of residents, performed chart audits, and provided oversight and consultation. The Chief Nurse Executive, Clinical Compliance Nurse, or Director of Clinical Programs were in daily contact with the regional nurse consultant and reviewed allegations.</p> <p>--All facility grievances filed since 04/01/14 were reviewed by the Administrator, DON, or Regional Nurse Consultant on 05/30/14 to determine if any items documented were a reportable event. The Administrator was notified of one allegation of possible abuse. The Administrator reported the allegations to the Office of Inspector General on 05/30/14. The Administrator, Social Services Director, or the Director of Nursing reviewed the grievances and incident/accident reports daily, until immediacy was lifted, which was initiated on 05/29/14, to determine if there were reportable allegations that had not been identified. The Social Services Director or the Director of Nursing reported to the Administrator any identified allegations of abuse, neglect, or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect, or misappropriation to the Office of Inspector General, Adult Protective Services, and the Ombudsman.</p> <p>--An emergency resident council meeting was held on 05/30/14; the Administrator and SDC attended the meeting to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns</p>	{F 225}			

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

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

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

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

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

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

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

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

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

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

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

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{F 225}	Continued From page 31 conferences. The interview further revealed resident family members that attended the care plan conferences were questioned about abuse/neglect concerns in the facility and educated on how to report an abuse/neglect concern. Interviews on 06/04/14 with the Administrator and the Regional Nurse Consultant revealed administrative oversight was completed weekly and will continue monthly after the Immediate Jeopardy was removed. Interviews on 06/04/14 with the DON, ADON, and SDC revealed observation of staff as they provided care was completed for any suspected abuse/neglect concerns on a daily basis for five residents and will continue weekly after the removal of the Immediate Jeopardy. Continued interviews revealed the reports were reported to the QA Committee to determine the need for additional education concerns or change of the plan. Interviews on 06/04/14 with Administrative Staff revealed a Quality Assurance meeting had been held weekly beginning 05/29/14 and will be held weekly for four weeks and then monthly. The interviews further revealed evaluations by the Committee would determine the frequency and length of ongoing audits. Further interviews revealed corporate oversight had been in place since 05/29/14, on a daily basis, until the Immediate Jeopardy was removed and will continue weekly for four weeks and then will continue monthly.	{F 225}			
{F 520} SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	{F 520}			

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{F 520}	Continued From page 32 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's performance improvement plan, "Performance Improvement with Abaqis," dated 2012, and the "Abuse, Neglect and Misappropriation" policy dated April 2013, it was determined the facility failed to maintain a Quality Assessment and Assurance Committee to develop and implement appropriate plans of action to correct identified quality deficiencies for	{F 520}	225 520 1. The allegation of abuse reported by residents # 32 and 35 were reported to the Office of Inspector General by 5/29/14 by the Director of Nursing and reported to APS, Ombudsman, MD and POA by 5/30/14 by the Director of Nursing, ADON or charge nurse. Resident # 32 and 35 have been physically assessed by a nurse and psychosocially assessed by the social services director by 5/30/14. Resident # 32 and 35 were interviewed and statement obtained by the house supervisor, director of nursing or social services director by 5/30/14. Alleged perpetrator for resident # 32 was suspended pending outcome of thorough investigation and alleged perpetrator for resident #35 is no longer employed by the facility. Thorough investigation initiated on residents #32, and 35 by 5/30/14 by the DON, ADCNs, Social services director or regional nurse consultant. All residents have been assessed for any signs and symptoms of abuse/neglect. Those residents with BiMs >8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 5/29/14. Those residents with BiMs < 8 were physically assessed by the ADONs for any signs and symptoms of abuse/neglect along with all resident POA's contacted by social services director or chaplain to question any abuse/neglect concerns by 6/1/14. 2. An audit of all personnel records, to include any counseling, coaching, suspension and/or termination forms, was completed by the Human Resources Director and results reviewed by the Chief Nursing Executive by 5/30/14, to ensure compliance with federal and state regulations related to reporting any suspected abuse/neglect allegations and the employment of staff.	6/30/14

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{F 520}	<p>Continued From page 33</p> <p>one (1) of three (3) sampled residents (Resident #32). On 05/25/14, staff observed bruising to Resident #32's arm and the resident made an allegation that "fat Pat" (identified by the facility as SRNA #2) "grabbed" his/her arm. Interview and record review revealed Administrative staff and the Quality Assurance Committee failed to ensure the allegations of abuse were reported immediately to State Agencies, failed to ensure residents were protected from further potential abuse while an investigation was conducted, and failed to ensure investigations of allegations included resident and staff interviews and assessment of other residents for signs of abuse and neglect. The facility failed to recognize that their established abuse policy for reporting abuse was not effective and therefore failed to implement any corrective actions to correct these problems. (Refer to F225, F226, and F490.)</p> <p>The facility's failure to ensure their Quality Assessment and Assurance Committee developed and implemented appropriate plans of action related to abuse prevention caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/24/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520) with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). The facility was notified of the Immediate Jeopardy on 05/29/14.</p> <p>An acceptable Allegation of Compliance was received on 06/02/14 which alleged removal of the Immediate Jeopardy on 05/31/14. A partial extended survey was conducted on 06/03/14</p>	{F 520}	<p>A review of all grievances and accidents/incidents from January 2014 to May 2014 was completed by DON, ADONs' SDC, MDS, by 5/30/14 to ensure all have been thoroughly investigated along with any suspected abuse/neglect identified was reported in accordance with state/federal law to ensure reporting guidelines have been met. 1 allegation was identified, reported in accordance with state/federal guidelines and thorough investigation completed.</p> <p>All residents were assessed for any suspected and/or allegations of abuse/neglect. Residents with BIMs score of > 8 were interviewed by the Social services director or chaplain by 5/30/14 for any suspected neglect issues and Residents with BIMs score of < 8 were assessed by DON, ADONs, FFN, or SDC by 5/30/14 for any s/s of suspected neglect along with residents POA's were contacted and questioned by social services director or chaplain by 5/30/14 for any suspected abuse/neglect concerns. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator, Regional Nurse Consultant or the Chief Nurse Executive by 5/30/14 for any indications of abuse/neglect concerns.</p> <p>Chart audits to include review of nurses notes, dietary notes, social services notes, quality of life notes and interdisciplinary notes were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or Regional Nurse Consultant by 5/30/14 for all residents to identify any suspected abuse/neglect allegations that have not been reported.</p> <p>3. The facility department managers, to include, administrator, DON, ADONs, SDC, MDS, wound</p>		

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{F 520}	<p>Continued From page 34 through 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F225, F226, and F490).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect and Misappropriation," dated April 2013 revealed facility staff would report and investigate all allegations of verbal, sexual, physical, and mental abuse, corporal punishment, neglect, and involuntary seclusion of the resident and resident exploitation as well as misappropriation of resident property. According to the policy, all allegations would be reported immediately to the Administrator and other officials as required and the alleged staff would be immediately removed from the care of all residents. In addition, the policy revealed the Administrator/designee would make reasonable efforts to investigate and address alleged reports, concerns, and grievances.</p> <p>Review of the facility's performance improvement plan titled, "Performance Improvement with Abaqis," dated 2012, revealed the facility would conduct an ongoing performance improvement program designed to systematically monitor, evaluate, and improve the quality of resident care. The plan further stated the facility's Performance Improvement (PI) process was to be incorporated into the ongoing weekly clinical processes and</p>	{F 520}	<p>care nurse, BOM, QOL, maintenance director, Housekeeping director, DM, Marketing/Admissions, SSD, RSM, FFN MR and Chaplain received education from the Regional Nurse Consultant on 5/29/14 regarding the abuse/neglect policy and procedure which included - appropriately identifying any suspected abuse/neglect allegations, appropriate reporting in accordance with state/federal guidelines, ensuring safety of the residents, and conducting a thorough investigation along with the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and question and include examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident to resident altercations to include verbal or physical, and taking belongings or exploitation. Post-test was administered and 100% score obtained, if manager did not score 100% on post-test, then manager will be immediately re-educated and post-test re-administered. This process will continue until manager obtains a 100% score on post-test.</p> <p>Once the facility Administrator, DON, ADONS, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN were re-educated on the abuse policy they were then assigned to re-educate the staff on the abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements, which started on 5/29/14. No employee will be allowed to work until abuse</p>		

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{F 520}	<p>Continued From page 35</p> <p>was to ensure immediate concerns identified were promptly investigated, which included allegations of abuse.</p> <p>Review of incident reports and interviews revealed staff observed bruising to Resident #32's arm on 05/25/14 and the resident reported "fat Pat" (identified by the facility as SRNA #2) "grabbed" his/her arm.</p> <p>Review of the Daily Standup Meeting documentation dated 05/26/14, revealed the observation of Resident #32's bruised arm and the allegation made by the resident were discussed in the meeting.</p> <p>Interview conducted with the Staff Development Coordinator (SDC) on 05/29/14 at 4:37 PM, revealed Quality Assurance (QA)/Standup meetings were conducted Monday through Friday. The SDC further stated she had attended the meeting on 05/26/14, and stated Resident #32's bruises and the statement made by Resident #32 had been discussed. However, the SDC stated the incident and the resident's statement had not been "discussed as an allegation of abuse" and the QA Committee had not recommended any actions to address the resident's report.</p> <p>An interview conducted with Assistant Director of Nursing (ADON) #1 on 05/29/14 at 5:31 PM revealed the facility's "quality concerns" were discussed during the Daily Standup Meetings, which were conducted Monday through Friday. ADON #1 confirmed Resident #32's statement that the SRNA had "grabbed" his/her arm and the bruises to the resident's arm had been discussed in the meeting with members of the QA</p>	{F 520}	<p>education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. Education regarding the abuse policy and procedure, to include identification/reporting and the Quality Assurance Performance Improvement process will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until abuse education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test.</p> <p>Staff questionnaire regarding abuse, to include the question, "What would you do if a resident told you that you were mean to them", is being administered by Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN to 10 different staff members daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating and reporting of abuse/neglect, and the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plan. Results of the staff questionnaire will be reported to the QA committee weekly for 4 weeks, starting on 5/29/14, to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will</p>		

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{F 520}	<p>Continued From page 36</p> <p>Committee on 05/26/14. The ADON further stated the incident had been reported to the DON and the Administrator, who were responsible for conducting abuse investigations. Therefore, he "felt like it had been addressed." ADON #1 further stated no other actions were recommended by members of the QA Committee when the incident was discussed on 05/26/14.</p> <p>An interview with the Director of Nursing (DON) on 05/29/14 at 6:06 PM revealed the facility's Daily Standup Meetings were conducted Monday through Friday and were part of the facility's Quality Assurance Program. The DON further stated the incident and actions which had been taken related to the bruises to Resident #32's arm, along with the resident's statement that the SRNA had grabbed his/her arm, were discussed with members of the QA Committee during the Daily Standup Meeting on 05/26/14. However, the DON stated the incident was not identified to be an allegation of abuse, and the QA Committee had not recommended any actions to be taken.</p> <p>An interview conducted with the Administrator on 05/29/14 at 6:17 PM confirmed that the facility had Daily Standup Meetings that were utilized as part of the facility's QA process and that facility concerns were discussed as a committee. The Administrator stated he had not attended the QA/Daily Standup Meeting on 05/26/14, when the incident related to the bruises observed on Resident #32's arm and the resident's allegation related to SRNA #2 had been discussed with members of the QA Committee. The Administrator stated he would have expected the facility's QA Committee to have determined the resident's report was an allegation of abuse. He stated facility staff should have reported and</p>	{F 520}	<p>determine at what frequency the staff questionnaire will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected Abuse/neglect was thoroughly investigated and completed along reporting guidelines are met.</p> <p>Hand in Hand training, module one, was initiated on 5/13/14 by SDC and completed on 6/4/14. There is an education calendar in which all modules have been scheduled to include all 6 modules over the next 6 months. Make up sessions will be offered until all employees have attended. New employees in orientation will receive the Hand in Hand training on a set schedule to ensure all 6 modules are completed.</p> <p>The Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN, will be on site daily for 4 weeks to perform walking rounds in which 10 residents (five with BIMs >8 and five with BIMs <8) will be visited by the department head and interviewed regarding staff treatment for those residents that can be interviewed and for those residents who are not able to be interviewed the department heads will visit the resident, skin check will be completed by nurse as well as speak to nurse and C.N.A. regarding any noted changes in resident behaviors. The facility department heads also will interview 10 different staff members daily regarding the types of abuse, who is the abuse coordinator, when is suspected abuse reported, what would you do if a resident told you that you were mean to them etc. which began on 5/29/14. Results of resident and staff</p>		

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{F 520}	<p>Continued From page 37 investigated the report in accordance with the facility's policy.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 06/02/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>--The allegation of abuse reported by Resident #32 was reported to the Office of Inspector General (OIG) on 05/27/14 by the DON. Resident #32 has a BIMS score greater than 8 and a statement was obtained on 05/25/14. The alleged perpetrator was suspended on 05/25/14. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the Assistant Directors of Nursing (ADONs) assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 Power of Attorneys (POAs) for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted.</p> <p>--The allegation of abuse related to Resident #33 that occurred on 05/24/14 was reported to OIG on 05/29/14 by the DON and reported to Adult Protective Services (APS), the Ombudsman, the resident's physician, and the POA on 05/30/14 by</p>	{F 520}	<p>questionnaire's will be reported to the Administrator, DON, Regional Nurse Consultant or VP of Operations daily and if the Administrator is not in the facility the Department Director conducting the questionnaires will telephone the Administrator or VP of Operations the results of the resident and staff questionnaires.</p> <p>The Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or PFN will notify Administrator of any concerns immediately regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect or misappropriation, ensuring resident is safe. A binder, which is passed on to each Department Head assigned to perform the resident and staff questionnaires daily, which contains a resident roster in which the interview date and shift is noted next to resident name to ensure that residents with BIMS >8 will be interviewed and residents with BIMS <8 will be visited, with skin checks completed, beginning on 5/29/14. The MDS Coordinators have the responsibility for updating the binder weekly to identify residents with BIMS >8 and residents with BIMS <8. If abuse, mistreatment, neglect or misappropriation is alleged during the interviews and or visits or reported by a staff member the Department Head will ensure the resident is safe, report to a charge nurse in which the charge nurse will remove the alleged perpetrator to a non-patient care area and notify the Administrator, Director of Nursing, and/or Social Services Direct/Abuse Coordinator. The alleged perpetrator will be suspended and a thorough investigation will begin immediately.</p>		

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{F 520}	<p>Continued From page 38</p> <p>the DON. A facility nurse assessed Resident #33 on 05/29/14 and the resident had a psychosocial assessment completed by the Social Services Director on 05/30/14. Resident #33 was interviewed and a statement was obtained by the facility's Social Services Director on 05/30/14. The alleged perpetrator was no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with a BIMS score less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>–The allegation of abuse reported by Resident #35 was reported to the Office of Inspector General on 05/29/14 by the DON and reported to APS, the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. Resident #35 was physically assessed by a nurse and psychosocially assessed by the Social Services Director on 05/30/14. Resident #35 was interviewed and a statement was obtained by the Social Services Director on 05/30/14. The alleged perpetrator is no longer employed by the facility. The facility's investigation was initiated</p>	{F 520}	<p>The Administrator, Director of Nursing, Social Services or a member of regional staff will review all resident and staff questionnaires daily for any grievances/concerns and/or suspected allegations of abuse/neglect. Any suspected allegations of abuse/neglect will be immediately reported in accordance with state/federal guidelines and thorough investigations of any suspected allegations of abuse/neglect along with any grievances/concerns will be initiated upon receipt, starting on 5/30/14.</p> <p>During care plan conference for each resident any potential allegation of abuse/neglect will be discussed and education will be provided on whom to report abuse/neglect concerns by the MDS coordinator.</p> <p>The Administrator, Social Services Director or the Director of Nursing will review, daily, the grievances and incident/accident reports, starting 5/29/14, to determine if there are reportable allegations that have not been identified. Social Services Director or the Director of Nursing will report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect or misappropriation in accordance with state/federal guidelines to meet reporting requirements.</p> <p>An emergency resident council meeting was held on 5/30/14, Administrator and SDC attended, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. All residents with BIMS < 8 POA's were attempted to be contacted by Social Services Director to discuss any abuse/neglect concerns and to provide</p>	

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{F 520}	<p>Continued From page 39</p> <p>and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>--All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted. The Administrator, the Regional Nurse Consultant, and the Chief Nurse Executive reviewed abuse/neglect audits, assessments, interviews, and questionnaires on 05/30/14 for any indications of abuse/neglect</p>	{F 520}	<p>education on whom to report any abuse/neglect concerns without fear of retribution on 5/30/14.</p> <p>Nursing Administration (DON, ADON, Unit Manager, Staff Development Coordinator, MDS staff, facility formulary nurse, medical records, or social service director) will review documentation in the chart in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on 5 residents starting on 6/5/14. Any of the above concerns identified, the member of Nursing Administration will first ensure resident is safe by performing an assessment, notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area (if on duty) and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>Administrator will keep an abuse investigation log that will include documentation of the following: ensure resident is protected, report is filed timely, perpetrator is removed from patient care area and thorough investigation is completed. The Administrator will review the log daily as well as one of the following: Signature Care Consultant, VP of Operations, or Special Projects Administrator along with Chief Operating Officer or Chief Nursing Executive will review log for compliance weekly, starting on 6/5/14 for 4 weeks, then monthly.</p> <p>In the event of any new reports of alleged abuse, neglect or misappropriation of property, one of the following will be contacted within 24 hours and then again prior to making the final five day investigation report to OIG: Signature Care</p>	

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{F 520}	Continued From page 40 concerns. -The facility's Regional Nurse Consultant from the corporate office re-educated the facility Administrator, the DON, the ADONs, the Minimum Data Set (MDS) Coordinator, the Staff Development Coordinator (SDC), the Director of Dining Services, the Business Office Manager, the Social Services Director, the Activities Director, the Chaplain, Marketing/Admissions, Medical Records, Human Resources, and Wound Care staff on 05/29/14 on the facility's abuse policy and procedure. The education included but was not limited to thorough investigations, reporting immediately, and the Quality Assurance Performance Improvement (QAPI) process, including reporting of concerns to the Administrator and floor staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and questions and included examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident-to-resident altercations to include verbal or physical, and taking belongings or exploitation. Department administrative managers were not allowed to return to work until abuse education was provided, post-tests administered, and a score of 100% obtained. If the manager did not score 100% on post-test, then the manager was immediately re-educated and re-tested. This process continued until all managers obtained a 100% score on the post-test. All post-tests were reviewed for compliance by the Chief Nursing Executive (CNE). -After the facility Administrator, DON, ADONs, Minimum Data Set (MDS) Coordinator, Staff	{F 520}	Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator or Chief Nursing Executive) will insure the resident is protected, report is filed timely, the perpetrator is removed from the patient care area and a thorough investigation is initiated and completed. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive or Chief Operating Officer weekly starting 6/5/14 for 4 weeks, then monthly. DON, ADONs, or SDC will observe the care delivery, for any suspected abuse/neglect concerns on 1 resident/unit daily (Monday through Friday) starting on 6/5/14 for 4 weeks. Any concerns noted the nursing administration will first ensure resident is safe by performing an assessment and notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed. 4. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive, or Chief Operating Officer, weekly for 4 weeks beginning 6/5/14, then monthly.		

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{F 520}	Continued From page 41 Development Coordinator (SDC), Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions staff, Medical Records staff or Director, Human Relations (HR) staff, or Wound Care staff were re-educated on the abuse policy, the Administrative staff was assigned to re-educate the staff on the abuse policy and procedure which included but was not limited to reporting, protection, and investigation requirements, which started on 05/29/14. The facility did not allow any employee to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and the post-test re-administered. This process continued until all employees obtained a 100% score on the post-test. Education regarding the abuse policy and procedure, including identification/reporting and the Quality Assurance Performance Improvement process was added in the orientation process for all newly hired staff members. No newly hired employee would be allowed to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and re-tested. This process continued until employees obtained a 100% score on the post-test. --Staff questionnaires regarding abuse, including the question, "What would you do if a resident told you that you were mean to them?" were administered by the Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain,	{F 520}	The Administrator or Signature Care Consultant will audit compliance of the above stated audits/reviews daily (M-F). Results of the audits/reviews, which include, resident interviews, resident skin checks, staff questionnaires, grievance log review, A/I review, chart documentation audits and care delivery audits will be reported to the QA committee weekly x 4 weeks to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits/reviews, along with monitoring for compliance, will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected neglect was investigated and completed along with reporting guidelines are met. A follow-up questionnaire will be completed by the Administrator, Director of Nursing , Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 different staff members daily for 4 weeks beginning 6/5/14, to ensure continued understanding regarding the abuse/neglect policy, appropriate reporting, identification, and implementing care plans to meet resident care needs. A Quality Assurance meeting will be held weekly for 4 weeks beginning 5/28/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue.		

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{F 520}	<p>Continued From page 42</p> <p>Marketing/Admissions, Medical Records, HR, or Wound Care staff to five staff members on each shift and different staff members until immediacy was removed. After removal of immediacy, ten staff questionnaires were administered to staff daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating, and reporting of abuse/neglect. The questionnaire also included questions related to the QAPI process to include reporting of concerns to the Administrator and floor staff participation in development of the QAPI plan. Results of the staff questionnaire were reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of the plan. At that time, based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigation of suspected abuse/neglect was investigated/completed and reporting guidelines were met.</p> <p>--HR performed an audit of all personnel files for any abuse concerns on 05/29/14. Items that were reviewed: Coaching and Counseling forms, suspension forms, and termination forms. Results of the audit were given to the Chief Nursing Executive on 05/30/14, to review for any abuse/neglect concerns that needed reporting. There were no concerns identified.</p> <p>--A nurse from the facility's regional team or corporate office had been on-site since 05/29/14 and remained in the facility daily until the jeopardy was removed. The nurses from the regional team or home office assisted with investigations,</p>	{F 520}	The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.		

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{F 520}	<p>Continued From page 43</p> <p>observed staff treatment of residents, performed chart audits, and provided oversight and consultation. The Chief Nurse Executive, Clinical Compliance Nurse, or Director of Clinical Programs were in daily contact with the regional nurse consultant and reviewed allegations.</p> <p>--All facility grievances filed since 04/01/14 were reviewed by the Administrator, DON, or Regional Nurse Consultant on 05/30/14 to determine if any items documented were a reportable event. The Administrator was notified of one allegation of possible abuse. The Administrator reported the allegations to the Office of Inspector General on 05/30/14. The Administrator, Social Services Director, or the Director of Nursing reviewed the grievances and incident/accident reports daily, until immediacy was lifted, which was initiated on 05/29/14, to determine if there were reportable allegations that had not been identified. The Social Services Director or the Director of Nursing reported to the Administrator any identified allegations of abuse, neglect, or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect, or misappropriation to the Office of Inspector General, Adult Protective Services, and the Ombudsman.</p> <p>--An emergency resident council meeting was held on 05/30/14; the Administrator and SDC attended the meeting to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. The Social Services Director attempted to contact the POAs of all residents with BIMS scores less than 8 to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect</p>	{F 520}			

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{F 520}	Continued From page 44 concerns without fear of retribution on 05/30/14. --The Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, and Wound Care Nurse (one per shift) were to be on-site each shift to perform walking rounds in which ten residents (five with BIMS scores greater than 8 and five with BIMS scores less than 8) were visited by the Department Head and those residents that could be interviewed were interviewed regarding the staff treatment. The Department Head visited and a nurse conducted a skin check on the residents that were not able to be interviewed. The Department Head also spoke to nursing staff and State Registered Nursing Assistants (SRNAs) regarding any noted changes in the residents' behaviors. The facility Department Head also interviewed five staff members each shift regarding the types of abuse, who the facility's Abuse Coordinator was, when to report suspected abuse, what to do if the resident reported you were mean to them, etc., which began on 05/29/14 and continued until the immediate jeopardy was lifted. Results of resident and staff questionnaires were reported to the Administrator, DON, Regional Nurse Consultant, or Vice President (VP) of Operations daily and if the Administrator was not in the facility, the Department Director conducted the questionnaires and telephoned the Administrator or VP of Operations with the results of the resident and staff questionnaires. This continued until the immediate jeopardy was lifted. --The DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office	{F 520}			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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{F 520}	Continued From page 45 Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff immediately notified the Administrator of any concerns regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect, or misappropriation and ensured the resident was safe. A binder (which contains a resident roster in which the interview date and shift is noted next to the resident name), which is passed on to each Department Head assigned to perform the resident and staff questionnaires each shift, to ensure that residents with BIMS scores greater than 8 were interviewed and residents with BIMS scores less than 8 were visited and skin checks completed, began on 05/29/14 and continued until the jeopardy was lifted. The MDS Coordinators had the responsibility for updating the binder weekly to identify residents with BIMS scores greater than 8 and residents with BIMS scores less than 8. If abuse, mistreatment, neglect, or misappropriation was alleged during the interviews or visits or reported by a staff member, the Department Head ensured the resident was safe, reported to a Charge Nurse, the Charge Nurse removed the alleged perpetrator to a non-patient care area, and notified the Administrator, Director of Nursing, and/or Social Services Director/Abuse Coordinator. The alleged perpetrator was suspended and an investigation began immediately. --The Administrator, Director of Nursing, Social Services Director, or a member of the facility's regional staff reviewed all resident and staff questionnaires daily for any grievances/concerns. Investigations of grievances/concerns were initiated upon receipt, starting on 05/30/14.	{F 520}			

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{F 520}	<p>Continued From page 46</p> <p>--Nursing Administration (DON, ADONs, Unit Managers, SDC, MDS staff, facility formulary nurse), or the Medical Records or Social Services Director, reviewed documentation in the Nursing Notes in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on ten different residents each day. If any of the above concerns were identified, the member of Nursing Administration first ensured the resident was safe by performing an assessment and then notified a Charge Nurse. The abuse policy was followed in which the alleged perpetrator was removed from a resident care area (if on duty) and the Administrator, DON, or Social Services Director was notified.</p> <p>--All resident charts were reviewed from 04/01/14 by Nursing Administration (DON, ADONs, Unit Manager, Staff Development Coordinator, MDS staff, Facility Formulary Nurse, Medical Records, Marketing/Admissions, or Social Services Director) or regional/corporate nurses by 05/30/14 for any documentation regarding abuse with no new incident being identified. Ten charts were reviewed by a member of Nursing Administration or the facility's regional or home office nurse daily to ensure that no other abuse allegations had been documented but not reported. This continued until the immediate jeopardy was removed.</p> <p>--The Administrator, Director of Nursing, and Social Services Director reviewed and discussed all abuse investigations daily to ensure that the residents were protected, the alleged perpetrator was removed from the resident care area, reports to the Office of Inspector General were filed</p>	{F 520}		

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{F 520}	<p>Continued From page 47</p> <p>timely, and a thorough investigation was completed. The Administrator maintained an abuse investigation log that included documentation of the following: ensured protection of residents, removed perpetrator from resident care area, reports to the Office of Inspector General filed timely, and thorough investigations completed. The Administrator and one of the following, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant, reviewed the abuse investigation to ensure protection of the resident; that the perpetrator was removed from the resident care area; that reports to the Office of Inspector General were filed timely; and that a thorough investigation had been completed. This will occur daily until removal of immediate jeopardy.</p> <p>--For new reports of alleged abuse, neglect, or misappropriation of property, after the immediate jeopardy was removed, one of the following was contacted prior to making the final five-day investigation report to OIG: Signature Care Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator, or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or Chief Nursing Executive) ensured the resident was protected, report was filed timely, the perpetrator was removed from the patient care area, and a thorough investigation was completed.</p> <p>--With any new report of alleged abuse, neglect, or misappropriation of property, one of the following was contacted within 24 hours to review the abuse investigation to ensure that a thorough investigation was completed and reporting timelines were met: Signature Care Consultant,</p>	{F 520}		

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{F 520}	<p>Continued From page 48</p> <p>VP of Operations, Chief Operating Office, Special Projects Administrator, or CNE.</p> <p>--All incident reports from January 2014 to 03/29/14 were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any concerns of suspected neglect by 05/30/14. None was identified.</p> <p>--During care plan conference for each resident, any abuse/neglect concerns were discussed and abuse/neglect education, to include reporting, was provided to the resident and/or POA with supporting documentation noted.</p> <p>--Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the CEO daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>--The DON, ADONs, or SDC observed the care delivery for any suspected abuse/neglect concerns on five residents daily until the removal of immediacy and then weekly (Monday through Friday). The results of the care delivery audits were reported to the QA Committee weekly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA Committee would determine at what frequency the audits needed to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigations of suspected abuse/neglect were investigated/completed and reporting guidelines were met.</p>	{F 520}			

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{F 520}	<p>Continued From page 49</p> <p>--A Quality Assurance meeting was held weekly for four weeks beginning 05/29/14, then monthly for recommendations and further follow-up regarding the above stated plan. At that time, based upon evaluation, the QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting was to be completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the Chief Executive Officer (CEO) daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interviews with Administrative Staff revealed the allegation involving Resident #32 was investigated and reported to the appropriate State agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation involving Resident #33 was investigated and reported to the appropriate state agency. The investigation included interviews</p>	{F 520}		

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{F 520}	<p>Continued From page 50</p> <p>with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation that involved Resident #35 was investigated and reported to the appropriate state agency. The investigation included interviews with Resident #35, staff, and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's assessments for signs and symptoms of abuse and resident interviews revealed the facility completed them on 05/29/14. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed as of 06/03/14, only six POAs had not been contacted so the facility sent the abuse/neglect questionnaire by certified mail to the POAs. A review of the abuse/neglect assessments, abuse/neglect audits, and abuse/neglect interviews revealed the Administrative staff provided validation and oversight.</p> <p>Review of Administrative staff education and testing, provided on 05/29/14, related to abuse/neglect policy, investigations, reporting, and the Quality Assessment process was reviewed and validated by the Chief Nursing Executive (CNE).</p> <p>Review of staff education and post-testing related to the abuse policy and procedure which included</p>	{F 520}			

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{F 520}	<p>Continued From page 51</p> <p>reporting, protection, and investigation requirements revealed the education was provided on 05/29/14, as per the AOC. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM, revealed during the staff in-service examples were given of different situations of abuse/neglect and the staff had to explain the appropriate actions. Further interview with the Regional Nurse Consultant revealed the facility had not hired any new employees.</p> <p>A review of the staff questionnaire regarding abuse was being done as reported in the AOC. Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed no issues had been identified through the staff questionnaires.</p> <p>Review of the HR Audits of personnel files revealed the CNE validated review by signature on the back of the audit forms. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed there were no issues identified with the review of the employee files.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed a corporate staff member had been at the facility since the jeopardy was identified and had been reviewing all allegations to ensure a thorough investigation was conducted. Further interview revealed the corporate staff was also conducting chart audits, observed staff treatment of residents, and provided consultation.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed all facility grievances filed since 04/01/14 were reviewed for possible allegations of abuse/neglect. The</p>	{F 520}			

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{F 520}	<p>Continued From page 52</p> <p>interview revealed one grievance was related to cigarettes that were missing. The incident was investigated with no concerns identified. Continued interview revealed the facility's smoking policy had recently been updated to account for all residents' cigarettes.</p> <p>Interviews on 06/04/14 with the Regional Nurse Consultant and SDC revealed a Resident Council meeting was held on 05/30/14 to discuss abuse/neglect concerns and education was provided on reporting abuse/neglect concerns without fear of retribution. The interview further revealed residents that did not attend the meeting were also provided education related to reporting abuse.</p> <p>Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed as of 05/29/14 a daily census was completed and residents were chosen by the Administrator to be interviewed and to observe staff as they provided care to the resident which was done by Administrative Staff. The interview further revealed staff providing care to residents with a BIMS score less than 8 were interviewed about changes in the resident. The Administrator or a member of the regional team validated the interviews and observations of care were completed.</p> <p>Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed a binder with all questionnaires related to abuse/neglect was passed to each Department Head assigned to distribute the questionnaires. The interview further revealed the staff had notified the Administrator with the results of the questionnaires. A review of the binder revealed</p>	{F 520}		

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{F 520}	<p>Continued From page 53</p> <p>no issues were identified. The binder contained a resident roster which included the dates and shifts the residents had been interviewed or assessed. The binder had been updated as BIMS scores changed. There were no issues identified during the interviews.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed the Administrator or regional team member had reviewed all questionnaires with no issues identified. A review of the questionnaires revealed a signature validated the questionnaires had been reviewed.</p> <p>Interview with Administrative Nursing Staff on 06/04/14 revealed resident charts had been reviewed each day for entries in the Nurse's Notes that could be related to abuse or neglect.</p> <p>Interview on 06/04/14 with Administrative Nursing Staff revealed all resident charts had been audited from 04/01/14 for any documentation regarding abuse and no new concerns were identified. The interviews revealed ten charts continued to be reviewed daily for any new documented evidence of abuse that was not reported.</p> <p>Interview on 06/04/14 with Administrative Staff and the Regional Nurse Consultant revealed all abuse investigations had been discussed and reviewed daily to ensure the facility's abuse policy was followed to ensure the resident was protected, the perpetrator was removed from the resident care area, the incident was reported timely, and an investigation was completed. Further interview revealed the Administrator maintained an abuse log to ensure all areas of</p>	{F 520}			

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{F 520}	<p>Continued From page 54</p> <p>the investigations were completed. Continued interviews revealed the Administrator and one corporate staff member reviewed investigations to ensure they were complete.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed after the Immediate Jeopardy was removed new reports of alleged abuse investigations will be reviewed by a Corporate Staff Member prior to the five-day report being sent to OIG. The Corporate Staff member will ensure the resident was protected, the incident was reported timely, the perpetrator was removed from patient care area, and a thorough investigation was completed.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed new reports of abuse or neglect will be reported to a Corporate Staff Member within 24 hours to ensure an investigation was completed and the reporting timelines were met.</p> <p>Interviews on 06/04/14 with Administrative Nursing Staff and the Regional Nurse Consultant revealed all incident reports that had been completed since January 2014 were reviewed for concerns related to abuse/neglect and none were identified.</p> <p>Interview on 06/04/14 with the MDS Coordinator revealed questions about concerns related to abuse/neglect and education about reporting abuse/neglect were added to the care plan conferences. The interview further revealed resident family members that attended the care plan conferences were questioned about abuse/neglect concerns in the facility and educated on how to report an abuse/neglect</p>	{F 520}			

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{F 520}	<p>Continued From page 55 concern.</p> <p>Interviews on 06/04/14 with the Administrator and the Regional Nurse Consultant revealed administrative oversight was completed weekly and will continue monthly after the Immediate Jeopardy was removed.</p> <p>Interviews on 06/04/14 with the DON, ADON, and SDC revealed observation of staff as they provided care was completed for any suspected abuse/neglect concerns on a daily basis for five residents and will continue weekly after the removal of the Immediate Jeopardy. Continued interviews revealed the reports were reported to the QA Committee to determine the need for additional education concerns or change of the plan.</p> <p>Interviews on 06/04/14 with Administrative Staff revealed a Quality Assurance meeting had been held weekly beginning 05/29/14 and will be held weekly for four weeks and then monthly. The interviews further revealed evaluations by the Committee would determine the frequency and length of ongoing audits. Further interviews revealed corporate oversight had been in place since 05/29/14, on a daily basis, until the Immediate Jeopardy was removed and will continue weekly for four weeks and then will continue monthly.</p>	{F 520}			

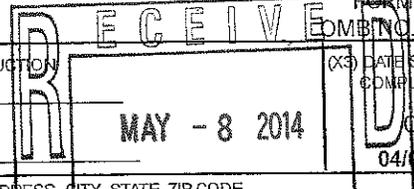
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501 Division of Health Care Southern Enforcement Branch
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F 000	<p>INITIAL COMMENTS</p> <p>Amended--</p> <p>A standard health survey/abbreviated standard survey (KY21503) was initiated on 03/24/14. Immediate Jeopardy was identified on 03/28/14 and was determined to exist on 03/08/14. The facility was notified of the Immediate Jeopardy on 03/28/14. An extended survey/abbreviated standard survey (KY21521) was conducted on 04/01/14 through 04/03/14. Both complaints were unsubstantiated.</p> <p>The facility admitted Resident #8 on 09/09/13 and received a copy of a History and Physical report from an acute care facility that revealed the resident had an allergy to Macroductin (antibiotic). Interview on 03/26/14, at 2:25 PM with Resident #8 revealed the resident had also informed facility staff on the day of admission to the facility that he/she was allergic to Macroductin. However, review of the admission assessment revealed facility staff failed to document the resident's allergy to Macroductin on documents in the resident's medical record. From 03/08/14 through 03/11/14, the facility administered seven (7) doses of Macroductin to the resident for treatment of a Urinary Tract Infection (UTI). On 03/11/14 Resident #8 complained of "tightness" in the chest. The resident asked the nurse what medications he/she had received and was told Macroductin. At that time, the resident informed the nurse he/she had an allergy to Macroductin, the nurse notified the physician, and the Macroductin was discontinued.</p> <p>Review of an Incident/Occurrence Investigation</p>	F 000	<p>Signature Healthcare of Pikeville does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the 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 privilege which the Facility does not waive any reserves the right to assert in any administrative, civil or criminal claim, action or proceeding.</p>	5/13/14.
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *5/8/14*

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

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F 000	Continued From page 1 completed by the facility dated 03/11/14 revealed Registered Nurse (RN) #1 reported she had reviewed medications with Resident #8 at the time of admission and had not been aware of the resident's allergy to Macrochantin. Review of the facility's investigation revealed the facility failed to include a review of the History and Physical provided to the facility by the acute care facility that indicated Resident #8 had an allergy to Macrochantin. In addition, review of documentation revealed the facility failed to interview Resident #8 during the investigation of the incident, and failed to report the incident to the appropriate state agencies. The facility failed to ensure residents were free from significant medication errors and failed to ensure the pharmacist reported any medication irregularities to the physician. In addition, the facility failed to implement corrective actions to correct the deficient practice. Deficiencies were cited at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F225) and 42 CFR 483.25 Quality of Care (F333). An acceptable Allegation of Compliance was received on 04/01/14, which alleged removal of the Immediate Jeopardy on 03/31/14. The State Agency determined the Immediate Jeopardy was removed on 03/31/14, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR	F 000			

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F 000	Continued From page 2 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	F 225	5/13/14
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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	F 225	1. The Physician for Resident #8 was notified by the staff nurse immediately upon identification of symptoms that may have been related to the administration of Macrochantin. Physician's orders were obtained immediately and intramuscular Solumedrol along with Benadryl by mouth was administered staff nurse on 3/11/14 to treat her symptoms. Residents allergies were updated in the chart, on the MAR, with the MD and Pharmacy, along with a sheet was added in the front of her medication administration record to identify all of the residents medication allergies, to include but not limited to, Macrochantin that was identified during the facilities investigation. Investigation was initiated, resident was interviewed along with POA in regards to resident allergies and allegies identified was compared to discharge summaries along with medication reconciliation forms from resident visits to hospital and outside consult visits. Any discrepancies were reviewed with the resident, POA and MD for clarification. The Physician was notified by the	

Assistant Director of Nursing for

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F 225	Continued From page 3 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 observation, interview, record review, review of the facility's investigation, and review of facility policies, it was determined the facility failed to ensure all allegations of resident neglect were investigated and reported immediately to the State Survey Agency and other officials in accordance with state law for one (1) of twenty-one (21) sampled residents (Resident #8). Review of the medical record revealed a copy of a History and Physical report from an acute care facility, dated 08/27/13, that revealed Resident #8 was allergic to Macrochantin (antibiotic). In addition, interview conducted with Resident #8 on 03/26/14 at 2:25 PM revealed the resident had told Registered Nurse (RN) #1 on the day of his/her admission to the facility that he/she was allergic to Macrochantin. Review of an Admission Assessment completed by Registered Nurse (RN) #1 for Resident #8, dated 09/09/13, revealed the nurse had not identified and/or documented the resident was allergic to Macrochantin. Documentation revealed that from 03/08/14 to 03/11/14, facility staff administered seven doses of Macrochantin to Resident #8. On 03/11/14, Resident #8 complained of chest tightness, asked the nurse what medications he/she had received, and was told by the nurse that she had received Macrochantin. Record review revealed the Macrochantin was discontinued and the facility conducted an investigation of the incident. The facility's	F 225	Resident #6 on 3/28/14 to clarify her allergy to Morphine. A sheet was added in front of her medication administration record to identify her allergy to Morphine. A care plan was initiated with interventions to decrease the risk of allergic reaction. Resident # 6 and #8 were both assessed for any s/s of neglect, none were identified. 2. An audit of all personnel records was completed by the Human Resources Director by 5/13/14, to ensure compliance of federal and state regulations related to employment of staff. A review of all grievances and incidents from January 2014 to April 2014 was completed by DON, ADONs' SDC, MDS, by 5/13/14 to ensure all have been thoroughly investigated along with any suspected neglect identified was reported in accordance with state law to ensure reporting guidelines have been met. None was identified. Residents with BIMs score of > 8 were interviewed by the Social services director by 5/13/14 for any suspected neglect issues and Residents with BIMs		

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F 225	<p>Continued From page 4</p> <p>investigation revealed RN #1 reviewed all medications with Resident #8 at the time of admission and had not been aware of any allergy the resident had to Macrochantin. However, based on a review of the facility's investigation, the facility failed to conduct a review of Resident #8's medical record that included the History and Physical from the acute care facility that indicated the resident had an allergy to Macrochantin and failed to report the incident of neglect to the appropriate state agencies.</p> <p>The facility's failure to immediately report all allegations of abuse, neglect, exploitation, and misappropriation of resident property, and failure to investigate an allegation of abuse or neglect caused or was likely to cause serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy with Substandard Quality of Care was determined to exist on 03/08/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F225) and 42 CFR 483.25 Quality of Care (F333). The facility was notified of the Immediate Jeopardy on 03/28/14.</p> <p>An acceptable Allegation of Compliance was received on 04/01/14 which alleged removal of the Immediate Jeopardy on 03/31/14. The State Agency determined the Immediate Jeopardy was removed on 03/31/14, prior to exit, which lowered the scope/severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR</p>	F 225	<p>score of < 8 were assessed by DON, ADONs, FFN, or SDC by 5/13/14 for any s/s of suspected neglect along with residents POA's were questioned by social services director by 5/13/14 for any suspected neglect concerns.</p> <p>All incident reports from January 2014 to March 29, 2014 have been reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator or Regional nurse consultant to identify any concerns of suspected neglect by 3/29/14. None were identified.</p> <p>Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or Regional Nurse Consultant on 3/27/14 for all residents to ensure allergies are appropriately identified. During the audit, allergy stickers on the outside of resident's charts were reviewed to ensure accuracy. A medication allergy sheet was completed for each resident on 3/27/14 by the Director of Nursing, Assistant director of Nursing, Staff</p>	
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development coordinator, MDS

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F 225	<p>Continued From page 5</p> <p>483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect, and Misappropriation," with a revision date of March 2013, revealed the Administrator would make all reasonable efforts to investigate and address alleged reports of abuse or neglect, concerns, and grievances. In addition, the policy revealed all allegations were to be reported within the timeframe allotted by the state agency. However, the policy did not define what constituted neglect.</p> <p>Review of Resident #8's medical record revealed the facility admitted the resident on 09/09/13 with diagnoses that included Chronic Ischemic Heart Disease, Atrial Fibrillation, and Coronary Artery Disease. Continued review of the medical record revealed a copy of a History and Physical report from a recent hospitalization, dated 08/27/13, that revealed Resident #8 was allergic to Macrodantin. Resident #8's attending physician at the facility documented his initials and the date 09/09/13 on the copy of the History and Physical report as acknowledgement of receipt/review of the report.</p> <p>Review of the Minimum Data Set (MDS) Significant Change assessment completed by the facility for Resident #8 on 12/25/13, revealed the facility assessed the resident to have a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident's cognition was intact.</p> <p>Review of the physician's orders for Resident #8</p>	F 225	<p>coordinator and Regional Nurse Consultant and placed in front of each resident's MARs. All allergies were clarified with the physician.</p> <p>3. The Medical Director received education from the Administrator, the Staff Development Coordinator, and the Regional Nurse Consultant on 3/28/14 regarding appropriately identifying allergies for residents.</p> <p>The Pharmacy Consultant received education on 3/28/14 from the Administrator, Director of Nursing, and Regional Nurse Consultant regarding reviewing of hospital discharge records for all residents to ensure that allergies are appropriately identified.</p> <p>The Pharmacy Consultants were on site on 3/29/14 and reviewed all resident records on 3/29/14 to ensure allergies have been appropriately identified.</p> <p>Education was initiated for licensed staff/Kentucky Medication aid on 3/27/14 by the Regional Nurse Consultant, Director of Nursing, and the Staff Development Coordinator regarding reviewing the hospital documentation upon admission or re-admission to ensure that allergies are</p>		

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F 225	<p>Continued From page 6</p> <p>dated 03/08/14, revealed the facility staff was to administer 100 milligrams (mg) of Macrochantin to Resident #8, by mouth, twice a day for ten days for a diagnosis of a Urinary Tract Infection.</p> <p>Review of the Medication Administration Record (MAR) for Resident #8 dated March 2014 revealed from 03/08/14 at 5:00 PM through 03/11/14 at 5:00 PM, Resident #8 received seven doses of 100 mg of Macrochantin.</p> <p>Review of a Communication and Progress Note for Resident #8 dated 03/11/14, at 9:30 PM, revealed Resident #8 complained of "chest tightness," asked the nurse what medications he/she had received, and was told by the nurse that he/she had received Macrochantin. Based on documentation review, facility staff notified the resident's physician of the resident's complaints, discontinued the Macrochantin, and conducted an investigation of the incident. The Communication and Progress Note also revealed the physician requested staff to administer 50 mg of Benadryl (allergy medicine) orally, and 120 mg of Solu-Medrol (anti-inflammatory) intramuscularly, "now" due to a possible allergic reaction.</p> <p>Review of an Incident/Occurrence Investigation completed by Assistant Director of Nursing (ADON) #1 dated 03/11/14, revealed Resident #8 received eight doses of Macrobid from 03/08/14 through 03/11/14. The investigation revealed the ADON had interviewed RN #1 who completed the admission nursing assessment for Resident #8 on 09/09/13, and noted RN #1 had reviewed all medications with Resident #8 at the time of admission and had not been aware of any allergy the resident had to Macrochantin. However, based on documentation, the facility failed to</p>	F 225	<p>appropriately identified. Post test was given upon completion of education. A score of 100% must be obtained before being allowed to work. Those staff not obtaining a passing score of 100% will be educated on the spot and re-tested.</p> <p>Education was completed for the Administrator, Director of Nursing, Staff Development Coordinator and Assistant Director of Nurses were educated by the Regional Nurse Consultant on 3/28/14 regarding reporting of neglect for any significant medication error.</p> <p>Education for all staff was initiated on 3/28/14 by the Staff Development Coordinator, Director of Nursing, Assistant Directors of Nursing or the Regional Nurse Consultant regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans.</p> <p>Education regarding reporting abuse, reporting of significant medication errors, obtaining allergies from</p>		

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F 225	<p>Continued From page 7</p> <p>conduct a review of the resident's medical record, to include a review of the History and Physical provided to the facility by the acute care facility that included the resident's allergy to Macrochantin, as part of the investigation. In addition, review of documentation revealed the facility failed to interview Resident #8 during the investigation of the incident and failed to report the incident to the appropriate state agencies.</p> <p>Resident #8 was observed on 03/25/14 at 10:55 AM to be alert and lying in bed. An interview was conducted with Resident #8 on 03/26/14 at 2:25 PM. Resident #8 stated he/she had informed RN #1 of his/her allergy to Macrochantin on the day he/she was admitted to the facility. The resident stated the facility had not informed him/her that they had administered Macrochantin to the resident until he/she began to have complaints of "chest tightness," asked the nurse what he/she was taking, and was told by the nurse she had given the resident Macrochantin.</p> <p>RN #1 acknowledged in interview conducted on 03/27/14 at 4:00 PM that she had completed the admission assessment for Resident #8 on 09/09/13. The RN stated she reviewed all hospital paperwork sent to the facility when the resident was admitted to the facility, including the History and Physical report dated 08/27/13 from the acute care facility, and did not recall information in the medical record that indicated Resident #8 had an allergy to Macrochantin. The RN stated she was unaware of how she had missed the documentation of the resident's allergy to Macrochantin.</p> <p>Interview conducted with RN #2 on 03/27/14, at 4:55 PM, revealed Resident #8 had reported</p>	F 225	<p>discharge summary, resident history or POA history, verification of allergy orders from physician as well as places on Medication Administration Record or medical record for placement of allergies will be included in orientation for licensed nursing and Certified Medication Techs.</p> <p>Interviews were completed on 3/27/14 by the Social Services Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or MDS Coordinators for residents with a BIMS score above 8 regarding their knowledge of allergies. This was compared to what is listed in the medical record and allergies were updated with assessment and/or physician order as needed.</p> <p>Residents with a BIM score less than 8, responsible party interviews were completed on 3/27/14 by Social Services Director, Director of Nursing, MDS Coordinators, Assistant Directors of Nursing, Administrator, or Regional Nurse Consultant to identify any allergies or concerns with medications. This was compared to what is listed in the medical record and allergies were updated with assessment and/or physician order as needed.</p>		

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F 225	<p>Continued From page 8</p> <p>chest tightness to her on 03/11/14, at 9:50 PM. The RN stated she immediately notified the resident's attending physician and an investigation was begun immediately. The RN stated she had not identified Resident #8 had a documented allergy to Macroductin and had not viewed the incident as neglect. The RN stated she was aware any allegation of abuse or neglect must be reported immediately to state agencies by the Administrator and the Administrator was responsible for notifying state agencies of incidents of abuse/neglect.</p> <p>Interview conducted with Resident #8's physician on 03/27/14, at 3:37 PM, revealed the resident "could have been harmed" from the administration of the Macroductin since the resident had experienced a "similar allergic reaction with tightness in the chest" after the resident received Macroductin during a previous hospitalization.</p> <p>Interview conducted with the Director of Nursing (DON) on 03/28/14, at 8:45 AM, revealed ADON #1 had investigated the incident related to the administration of Macroductin to Resident #8, and acknowledged the facility had not reported the incident to the state agencies as indicated in the facility's policy because they had not identified the incident as abuse or neglect. The DON stated they had not identified the documentation located in the resident's medical record on a History and Physical report dated 08/27/13 from the acute care facility indicating the resident was allergic to Macroductin. The DON stated when nurses completed an admission assessment on any new or readmitted resident they were required to review all hospital paperwork sent to the facility.</p>	F 225	<p>Allergies will be identified on day of admission and/or re-admission by the admitting nurse on the nursing admission information document. The admitting nurse will document allergies on the resident's medication allergy record that will be placed in the front of the Medication Administration Record for that resident. The admitting nurse will review the residents allergies with the resident and/or POA for confirmation. A care plan will be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The procedure which includes identification of allergies on day of admission/re-admission by the admitting nurse along with documenting the allergies on the medication allergy record, the nursing admission assessment and physician orders and look at discharge summaries and all paperwork sent by the hospital, along with interview of resident/POA will also be included in orientation for new staff. Physician will be notified of any allergies by the charge nurse following review of all documents sent by hospital, resident and of POA interview.</p> <p>Charts for newly admitted residents and re-admitted residents will be reviewed</p>		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 9</p> <p>Interview conducted with Assistant Director of Nursing (ADON) #1 on 04/03/14, at 1:40 PM revealed she had completed the Incident/Occurrence Investigation on 03/11/14 and had not identified Resident #8 had an allergy documented on the History and Physical report dated 08/27/13 from the acute care facility. The ADON stated she had determined the resident had experienced a new allergy to the medication and had not identified the incident as abuse or neglect or as a medication error.</p> <p>Interview conducted with the Administrator on 03/28/14, at 9:00 AM, revealed he was responsible to report allegations of abuse and neglect to the state agencies. The Administrator stated the incident related to the administration of Macrochantin to Resident #8 had not been reported to the state agencies because the facility had not identified the incident as an allegation of abuse or neglect.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 04/01/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The physician for Resident #8 was notified by the staff nurse immediately upon identification of symptoms that may have been related to the administration of Macrochantin. Physician's orders were obtained immediately and intramuscular Solu-Medrol along with Benadryl by mouth was administered by the staff nurse on 03/11/14 to treat the resident's symptoms. The treatment was effective as evidenced by every shift assessment along with supporting documentation. The resident was monitored by staff nurses to ensure continued effectiveness.</p>	F 225	<p>and discussed in the Daily Clinical Meeting on weekdays attended by the Director of Nursing, MDS Coordinators, Social Service Director, Medical Records, Staff Development Coordinator, Assistant Directors of Nursing, Activities Director, Dietary Manager and Chaplain, with a comparison review completed at that time of the resident's nursing admission packet and their medication allergy form, against the hospital discharge summary and/or discharge documentation of resident allergies, to ensure that allergies are appropriately identified. On weekends, two charge nurses will review the discharge documentation and history and physical for newly admitted or re-admitted residents to ensure allergies are appropriately identified as well as all paperwork is complete accurate, care plan updated, physician notification complete and all allergy lists updated or initiated.</p> <p>Allergy stickers and allergy list were updated for all residents to include all medication allergies identified. This was completed by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development</p>		

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F 225	Continued From page 10 The physician was notified by the Assistant Director of Nursing (ADON) for Resident #6 on 03/28/14 to clarify the resident's allergy to Morphine. A sheet was added in front of the resident's medication administration record (MAR) to identify the resident's allergy to Morphine. A care plan was initiated with interventions to decrease the risk of an allergic reaction. Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), MDS Coordinators, and Regional Nurse Consultant on 03/27/14 for all residents to ensure allergies were appropriately identified. During the audit, allergy stickers on the outside of residents' charts were reviewed to ensure accuracy. A medication allergy sheet was completed for each resident on 03/27/14 by the DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant and placed in front of each resident's MARs. All allergies were clarified with the physician. The Regional Nurse Consultant, DON, and SDC initiated education for licensed staff and Kentucky Medication Aides (KMAs) on 03/27/14 and advised staff to review hospital documentation upon each resident admission or readmission to ensure allergies were appropriately identified. Licensed nursing staff/KMAs were not allowed to work prior to receiving the above stated education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those	F 225	Coordinator, or Regional Nurse Consultant on 3/28/14. Education was provided for Licensed Nursing Staff/Kentucky Medication Aide by the Director of Nursing, Assistant Director of Nursing, the Staff Development Coordinator, or the Regional Nurse Consultant regarding the above stated plan on 3/28/14 to include admitting nurse reviewing all paperwork forward from the hospital, interview with resident/POA, verifying allergies with physician, noting allergies on the allergy sticker, allergy listing, physician orders, and MARS. Nursing Administraton to include the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordiantor, MDS Coordiantors, Facility Formulary Nurse or Regional Nurse Conslutant are reviewing every physician order daily (Monday – Friday) to audit for medication or any other orders for appropriateness, any new allergy orders, if new medications are listed and compared to allergy list. Education was provided by the Regional Nurse Consultant on 3/28/14 for the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff		

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F 225	<p>Continued From page 11</p> <p>staff members not obtaining a passing score of 100-percent would be educated on-the spot and retested.</p> <p>Resident #8's attending physician, who is also the facility's Medical Director, received education from the Administrator, SDC, and the Regional Nurse Consultant on 03/28/14 regarding appropriately identifying resident allergies.</p> <p>The Administrator, DON, and Regional Nurse Consultant provided education to the Pharmacy Consultant on 03/28/14 regarding reviewing hospital discharge records for all residents to ensure allergies were appropriately identified.</p> <p>The Pharmacy Consultants were on-site on 03/29/14 and reviewed all resident records to ensure allergies were appropriately identified.</p> <p>The Regional Nurse Consultant provided education to the Administrator, DON, SDC, and ADONs on 03/28/14 regarding reporting of neglect for any significant medication error.</p> <p>The SDC, DON, ADONs, and the Regional Nurse Consultant initiated staff education on 03/28/14 regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, the Quality Assurance Performance Improvement (QAPI) process to include reporting of concerns to the Administrator, and front line staff participation in development of QAPI plans. Staff was not permitted to work prior to receiving the education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those staff members not obtaining a passing score of</p>	F 225	<p>Development Coordinator, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manager and Admissions Director regarding the Quality Assurance Process and appropriate methods of identification of concerns including significant medication errors, failure to report neglect, auditing pharmacy services.</p> <p>During care plan conference for each resident the allergy list will also be reviewed for any updates.</p> <p>Medication pass audits were completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant for all nurses and Certified Medication Technicians working on 3/28/14 to ensure that allergies are appropriately identified and medications are administered without significant medication error. Medication pass audits will be completed for all nurses and certified medication technicians during their initial medication pass for shifts scheduled after 3/28/14 until all nurses and certified medication technicians have</p>		

had a medication audit completed.