

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

PRINTED: 10/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/10/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1026 EUCLID AVENUE PAINTSVILLE, KY 41241	
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY19125, KY19128) was initiated on 10/09/12 and concluded on 10/10/12. KY19125 was substantiated with deficient practice identified. KY19128 was unsubstantiated with deficient practice identified. Deficiencies were cited at "E" level.	F 000	Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure efforts to resolve resident grievances were made promptly. A group interview conducted on 10/09/12, with five of five alert/oriented residents (Residents E, F, G, H, and I) revealed call lights were not always answered timely. In addition, a review of Resident Council meeting minutes for nine of the last ten months (January, February, April, May, June, July, August, September, and October 2012) revealed residents had expressed concerns to the facility related to call lights not always being answered timely. However, a review of documentation and interviews revealed the facility failed to resolve the grievances or to inform the residents of any actions taken. The findings include:	F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES It is the policy of this facility to promptly respond and to attempt to resolve any grievances the resident may have, including those with respect to the behavior of other residents and to inform residents of the actions taken to resolve the grievance. This is evidenced by the following:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Deborah F. [Signature]* TITLE Administrator (08) DATE 11/7/12

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 166	<p>Continued From page 1</p> <p>A review of the facility's Grievance Policy (no date given) revealed grievances and/or complaints would be submitted in writing and signed by the resident or the person filing the grievance on behalf of the resident. According to the policy, the resident or the person filing the written grievance and/or complaint on behalf of the resident would be informed of the findings of the investigation and the actions that would be and/or were taken to correct any identified problems. The policy also revealed any complaints of alleged abuse, neglect, mistreatment, or injuries of unknown origin would be reported to the Administrator immediately. The policy revealed the Administrator would review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken.</p> <p>A group interview was conducted with five alert/oriented residents (Residents E, F, G, H, and I) on 10/09/12 at 9:30 AM. The residents complained the call lights were not always answered timely. The residents revealed there was no particular shift involved and stated the incidents had occurred on all shifts. Residents confirmed they had made the facility aware of the complaints; however, they had never received a response from the facility.</p> <p>A review of Resident Council meeting minutes for nine of the last ten months (January, February, April, May, June, July, August, September, and October 2012) revealed the residents expressed concerns to the facility related to call lights not always being answered timely. However, there was no evidence that the facility resolved these grievances or that the facility informed the</p>	F 166	<p>1. Resident I was discharged to home on 10/12/2012.</p> <p>Resident E, F, G and H was interviewed on 11-05-2012 by Kathy Meadows, Social Services to determine if there are other grievances unrelated to call lights.</p> <p>Any identified grievances will be investigated by the respective department head and the residents will be notified of the resolution by the department head or Kathy Meadows, Social Services.</p> <p>Residents E, F, G, and H will be interviewed weekly for 3 months to determine if call lights are being answered timely or if they have other grievances unrelated to call lights. This will be completed by Kathy Meadows or Misty Pennington, Social Services.</p> <p>Any grievance identified during the weekly interview (for any of these residents) will be investigated by the respective department heads and the respective residents will be informed of the investigation and plans to resolve the grievance by the department head, Kathy Meadows or Misty Pennington, Social Services.</p> <p>Any/all grievances identified during this interview process will be reported to the facility Administrator by the person completing the interview/grievance form and will be reviewed at the next grievance committee meeting.</p>		

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F 166	Continued From page 2 residents of any actions taken. 1. Resident Council minutes dated 01/03/12 confirmed residents had expressed to the facility that the call lights were not always answered timely. A review of in-service rosters for facility staff dated 01/04/12 and 01/05/12 revealed staff was educated by the facility on answering call lights in a timely manner. The rosters also revealed staff was in-serviced again on 01/31/12 and 02/02/12 regarding answering call lights in a timely manner. 2. Resident Council minutes dated 02/07/12 revealed the residents had complained State Registered Nursing Assistants (SRNAs) were slow to answer the residents' call lights. 3. Resident Council minutes dated 04/03/12 revealed complaints that the residents' call lights were not answered timely. 4. Resident Council minutes dated 05/01/12 revealed the residents complained staff was turning off call lights and not helping or coming back to help. 5. Resident Council minutes dated 06/05/12 revealed the residents complained that call lights were not being answered promptly. 6. Resident Council minutes dated 07/03/12 revealed the residents complained staff was not answering call lights in a timely manner or was turning the call lights off and not returning to assist the residents. A review of in-service rosters for facility staff dated 07/06/12, 07/10/12, and 07/24/12 revealed staff was educated by the	F 166	2. As a result of this being a complaint through resident council, all residents have been identified as having the potential to be affected as it relates to call lights. Kathy Meadows, Social Services interviewed all interviewable residents in the facility to determine if residents have other complaints/grievances unrelated to call lights. This was completed on 10/16/12 and 10/17/12. The families of all residents that were not interviewed will be contacted to determine if they have grievances related to the care or services their family member receives. This will be completed by Kathy Meadows, Social Services. All grievances or complaints identified during either resident or family interviews will be reported to the facility Administrator by Kathy Meadows, Social Services and will be investigated by the respective department manager. Any grievance/complaint (identified during these interviews) related to abuse, neglect or misappropriation of resident property will be reported to the facility Administrator and the appropriate state agencies according to facility policy. The results of the investigation and the plan to resolve or the resolution will be reported to the respective resident or family member by	

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F 166	<p>Continued From page 3</p> <p>facility on answering call lights in a timely manner.</p> <p>7. Resident Council minutes dated 08/07/12 revealed residents complained call lights were not being answered in a timely manner.</p> <p>8. Resident Council minutes dated 09/04/12 revealed the residents complained staff was turning off the residents' call lights and telling residents they will come back, however, they do not return to assist the residents. A review of in-service rosters for facility staff dated 09/27/12 revealed staff was educated by the facility on answering call lights in a timely manner.</p> <p>9. Resident Council minutes dated 10/02/12 revealed residents complained staff was turning off the call lights and not returning to provide the care the residents require in a timely manner.</p> <p>An interview with Social Worker (SW) #1 on 10/09/12 at 10:30 AM, revealed she attended the Resident Council meetings and was responsible for completing grievance forms for all complaints she received at the meetings. The SW stated she completes the grievance forms the same day and takes a copy of the form to the pertinent Department Manager to address. According to the SW, the Department Manager was required to address the issue, write up a response on the form, and return it to the SW to log and file the complaint/grievance. The SW stated the Department Managers were responsible to notify the residents of the outcome of the grievance/complaint. The SW further stated that she read the minutes of the previous month's meeting to the Council for review. The SW revealed she had previously spoken with the</p>	F 166	<p>either the person investigating and involved in the resolution or Kathy Meadows or Misty Pennington Social Services.</p> <p>All grievances/complaints identified during these interviews will be discussed in the grievance committee meeting and will include the grievance and investigation, resolution, satisfaction of resident/family with resolution, any further action to prevent a re-occurrence and reporting to appropriate state agencies if applicable.</p> <p>3. A grievance committee was formed on October 11, 2012 by Deborah Fitzpatrick, Administrator. In addition to the Administrator other members include various Department Managers and the Assistant Administrator. See Attachment #1.</p> <p>On October 16, 2012 the following policies were revised and finalized by the grievance committee. See attachment #2, #3, and #4: Filing Grievances/Complaints Grievance Complaint Log Grievances/Complaints - Staff Responsibility</p> <p>On October 16, 2012 a new Complaint/Grievance Report Form was adopted which includes filing and investigation of grievances or complaints, resolution, satisfaction with resolution and reporting of investigation and resolution. See Attachment #5.</p>	

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F 166	<p>Continued From page 4</p> <p>Administrator and the Director of Nursing (DON) regarding the residents' complaints regarding call lights not being answered promptly but could not recall the date and was unaware of what had been done to correct or resolve the issue. The SW stated the grievance/complaint form for the call light issue would have been given to the DON or her designee to address. The SW stated she had not discussed the resolution of the grievances/complaints with the residents related to the call lights not being answered promptly and thought the Department Managers were responsible for this.</p> <p>An interview conducted with the DON on 10/10/12 at 11:50 AM, revealed she had been aware of the grievances/complaints made by the residents regarding call lights not being answered in a timely manner. The DON stated she had provided in-services to the nursing staff and the facility had also done random call light checks. The DON stated she had participated along with the Assistant Administrator (AA). The DON stated they would randomly go into a resident's room, pull the call light, and wait to see how long it took the staff to respond. The DON stated she was not aware of the most recent Resident Council meeting held on 10/02/12, and the resident's grievances/complaints of the staff still not answering the call lights timely. The DON stated the Assistant Director of Nursing (ADON) may have received the grievance/complaint form. The DON also stated she had not attended Resident Council meetings to report to the residents regarding the call light concerns. The DON stated she had thought the concerns had been resolved and had not been aware she should have addressed the residents regarding</p>	F 166	<p>On October 16, 2012 a new Grievance Complaint Log was adopted for tracking grievances and complaints. See attachment #6.</p> <p>On October 16, 2012 a separate Resident Council Departmental Response Form was adopted for investigation of complaints through resident council and resolution of complaints. See attachment #7.</p> <p>All staff will be in-serviced on the new facility policies regarding complaints/grievances, the new forms and where these policies and forms will be kept for easy access for staff. This will be completed by Administrative Staff and Social Services.</p> <p>The new grievance and complaint forms will be placed at each nursing station and all other departments by Kathy Meadows, Social Services and Misty Pennington, Social Services.</p> <p>The new/revised policies will be kept at each nursing station and all other departments for easy access by staff.</p> <p>The time and date of the resident council meeting will be changed (with the permission of resident council) to a time that will allow both Social Workers and more residents to participate in resident council. This will be discussed in the next resident council meeting (Scheduled for 11/6/2012) by Kathy Meadows and Misty Pennington, Social Services.</p>		

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F 166	<p>Continued From page 5</p> <p>the resolution or outcome of the grievance/complaint and of the interventions that the facility had put into place.</p> <p>An interview conducted with the AA on 10/10/12 at 2:40 PM, revealed she was responsible for the Quality Assurance program for the facility. The AA stated she had been monitoring for untimely answering of call lights on an ongoing basis. The AA stated she had been aware the problem was continuing, and stated the only measures taken by the facility were to provide in-services to the staff and monitor call lights to check for timeliness of being answered. The AA stated they had not changed the interventions after the problem continued for the last nine of ten months. The AA stated she had only observed one call light that had not been answered timely during the observations. The AA stated she was not responsible for reviewing all grievances/complaints to ensure they had been addressed appropriately and the residents had been informed of the resolution and the interventions that were put into place.</p> <p>An interview conducted with the Administrator on 10/10/12 at 2:50 PM, revealed staff was required to notify her of the continuing grievances/complaints raised by residents at the monthly Resident Council meeting regarding call lights not being answered in a timely manner, but they had failed to notify her of the residents' continuing complaints. The Administrator also stated the Department Managers were required to follow up with the residents regarding any grievance/complaint with the resolution and/or interventions that were put into place by the facility. The Administrator stated the DON would</p>	F 166	<p>Activities staff will remind residents the day before resident council to encourage more participation.</p> <p>The Resident Council President will be notified of any resolutions to grievances identified in the previous resident council meeting.</p> <p>The Resident Council President will be invited to attend the facility Grievance Committee meeting to review the grievance and the resolution.</p> <p>The resident expectation of a reasonable time for a call light to be answered will be discussed in resident council. Kathy Meadows and Misty Pennington Social Services will complete this.</p> <p>Staff in-servicing regarding answering of call lights began on 10/12/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. See attachment #8.</p> <p>4. On October 11, 2012 a grievance committee was formed (consisting of various department managers, the Administrator and Assistant Administrator) as part of CQI and will meet weekly. The facility Administrator, Deborah Fitzpatrick is Chairman of this committee.</p> <p>The responsibility of the committee is to review all grievances and their investigation, any and all actions taken to resolve the grievance, resident and family satisfaction with the response from the facility and the resolution, and any further actions which may be suggested by the committee to prevent a repeat occurrence. This will be ongoing.</p>	

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F 186	Continued From page 6 have been responsible to follow up with the Resident Council. The Administrator stated she was responsible for reviewing all grievances; however, the grievances regarding the call lights not being answered timely had not been forwarded to her. The Administrator also stated any grievance/complaint that arises should be addressed again if it continues to be an issue and a new plan created to address the issue.	F 166	As part of CQI, twelve (12) residents will be interviewed weekly to determine if call lights are being answered timely and if residents have other grievances/complaints. This will be completed by Kathy Meadows and Misty Pennington, Social Services and Marie Pennington, Activity Director. This will be completed for 6 months and re-evaluated at that time.		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	All grievances/ complaints will be reported quarterly through CQI by Emily Jones Gray, Assistant Administrator. The Medical Director is part of the CQI team and will be informed during CQI of the findings. As part of CQI a room inspection was completed on October 15, 2012 by Kitty Hammon, Housekeeping/Laundry Supervisor. Proper placement of call lights was part of this audit. As a continued monitoring for proper placement of call lights (to ensure that call lights are in reach of residents) housekeeping will document daily the position of the call lights when they are in the resident rooms. If call lights are not in reach of the resident the housekeeping employee should place the call light in reach of the resident and document where the call light was. She should then report this to the nurse. This will be ongoing. The Housekeeping Supervisor will review the call light logs weekly to determine if there are patterns in particular residents call lights. These finding will be reported to the Director of Nursing for resolution and will also be reported weekly in the Grievance Committee and quarterly through CQI by Emily Jones Gray. This will be ongoing.		

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F 225	<p>Continued From page 7</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to ensure an allegation of abuse was immediately reported to the state survey and certification agency for one of four sampled residents (Resident #1) and four of four unsampled residents (Residents A, B, C, and D). On 09/26/12, the Director of Nursing (DON) was made aware of an allegation of abuse which involved Resident #1. Interview revealed the allegation was investigated but was not reported to state agencies. On 04/10/12, the facility was made aware of an allegation of sexual abuse which involved Resident A. Interviews revealed the allegation was investigated but not reported to state agencies. On 04/16/12, the facility was made aware of an allegation of verbal abuse involving Resident B. Interviews revealed the allegation was investigated but not reported to state agencies. On 04/30/12, the facility was made aware of an allegation of physical abuse involving Resident C. Interviews revealed the allegation was investigated but not reported to state agencies. On 07/05/12, the facility was</p>	F 225	<p>Twelve (12) Random call light checks will be completed weekly to determine if call lights are being answered timely. This will be completed by various staff assigned by the department managers. This will be done for 3 months at a minimum and will be re-evaluated by the Grievance Committee.</p> <p>A walk through of each nursing unit will be completed at a minimum of 3 days per week by various department managers. The walk through will include appearance of room/bathroom/resident and location of call light. During this walk through each resident will be asked specifically if they have any issues with staff responding to their call light. The results of these audits will be reported weekly in the Grievance committee and quarterly through CQI by Emily Jones Gray. This will be completed for 6 months and will be re-evaluated by the Grievance Committee.</p> <p>5. Date of Completion is 11/24/12</p> <p>F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>It is the policy of this facility to thoroughly investigate all allegations and to prevent further potential abuse while the investigation is in progress. It is the policy of this facility to report the investigations to the facility Administrator or his designated representative and to other officials in accordance with State law (including the</p>	

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F 225	<p>Continued From page 8</p> <p>made aware of an allegation of verbal abuse involving Resident D. Interviews revealed the allegation was investigated but not reported to state agencies.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Resident Protection Policy, last reviewed 09/25/12, revealed when allegations of mistreatment, abuse, misappropriation of property, or neglect were received, the Administrator or DON would immediately report the incident to the Division of Licensing and Regulation agency, Adult Protective Services, and other agencies as appropriate.</p> <p>1. A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 01/30/12 with diagnoses of Diabetes, Renal Failure, and Legally Blind. A review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment dated 08/09/12 revealed facility staff assessed the resident to be alert and oriented, with a Brief Interview for Mental Status (BIMS) score of 15. Further review revealed Resident #1 was assessed to require extensive assistance of one staff member for dressing, toileting, and personal hygiene.</p> <p>An interview with Resident #1 on 10/09/12 at 8:15 AM, revealed the resident had reported an allegation of abuse to the DON but the resident was unsure of the exact date the conversation occurred. The resident stated, "I told her the aide (referred to Certified Nurse Aide #15 by name) was always in a big hurry to do things, and the aide hurts my bad leg by being rough and in a big</p>	F 225	<p>State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified to take appropriate corrective action. This is evidenced by the following:</p> <p>1. The initial complaint and the investigation for Resident #1, A, B, C, D will be sent to the State and APS.</p> <p>The current facility residents identified during the survey as being affected by the alleged deficient practice were interviewed (as well as their respective family members) by Kathy Meadows, Social Services on 10/16/2012 regarding previous grievances/complaints and any new grievances and complaints. No new grievances/complaints were identified.</p> <p>2. Kathy Meadows, Social Services interviewed all interviewable residents in the facility to determine if residents have other complaints/grievances unrelated to call lights. This was completed on 10/16/12 and 10/17/12.</p> <p>The families of all residents that were not interviewed will be contacted to determine if they have grievances related to the care or services their family member receives. This will be completed by Kathy Meadows, Social Services.</p> <p>Any grievance/complaint (identified during these interviews) related to abuse, neglect or</p>		

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F 225	<p>Continued From page 9</p> <p>hurry." Further interview revealed the resident stated he/she "didn't feel like [the CNA] was intentionally trying to hurt me."</p> <p>Interview with CNA #15 on 10/09/12 at 11:30 AM, revealed she had not been contacted by the DON, or the facility, related to the allegation of abuse which involved Resident #1. The CNA denied being rough or in a hurry when Resident #1 was provided assistance with care.</p> <p>Interview with the DON on 10/09/12 at 8:30 AM, confirmed Resident #1 had informed her of an allegation of abuse which involved CNA #15. Continued interview revealed the allegation was not reported to the appropriate state agencies. The DON stated the allegation was not reported to state agencies because CNA #15 had already been suspended, pending a separate allegation of abuse. The DON stated the allegation which involved Resident #1 was investigated along with the investigation that was being conducted at the time Resident #1 voiced the allegation.</p> <p>2. A review of a facility grievance/complaint form dated 04/10/12 revealed Resident A's family had reported to Social Worker (SW) #2 an allegation of sexual abuse. The facility had investigated the allegation and had determined the allegation to be unsubstantiated on 04/11/12. However, the facility had failed to notify the appropriate licensing agencies.</p> <p>An interview conducted with SW#2 on 10/10/12 at 9:15 AM, revealed she had received the allegation from Resident A's family member. The SW stated she had written the allegation on a grievance/complaint form. The SW stated either</p>	F 225	<p>misappropriation of resident property will be reported to the Administrator/designated representative and the appropriate state agencies according to facility policy. See attachment #11.</p> <p>The investigations of any grievance/complaints related to abuse, neglect or misappropriation of resident property will be reported to the Administrator or his/her designated representative and the State survey and certification within 5 working days.</p> <p>3. A grievance committee was formed on October 11, 2012 by Deborah Fitzpatrick, Administrator. In addition to the Administrator other members include various Department Managers and the Assistant Administrator. See attachment #1.</p> <p>All staff will be in-serviced regarding abuse reporting, definitions of abuse, neglect and misappropriation of resident property. This will be completed by Administrative Staff or Social Services.</p> <p>In-services for nursing staff were started on 10/12/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. See attachment #8.</p> <p>The local Ombudsman gave a presentation on 10/17/12 for all staff regarding Resident Rights. See attachment #9.</p>		

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F 225	<p>Continued From page 10</p> <p>she, the DON, the Assistant Director of Nursing (ADON), or the Administrator was responsible for notifying the appropriate licensing agencies. The SW stated although she had reported the allegation to the DON to investigate, the SW failed to notify all the appropriate state agencies, including the licensing agencies.</p> <p>An interview conducted with the DON on 10/10/12 at 11:50 AM, revealed the allegation had been reported to her by SW #2, and she initiated the investigation. The DON also stated the allegation had not been reported to the licensing agencies and should have been.</p> <p>3. A review of a facility grievance/complaint form dated 04/16/12 revealed Resident B's family reported to SW #1 an allegation of verbal abuse. The facility investigated the allegation and determined the allegation to be unsubstantiated on 04/23/12. However, the facility failed to notify the appropriate state agencies, including the licensing agencies, of the allegation of abuse.</p> <p>An interview conducted with SW #1 on 10/10/12 at 9:50 AM, revealed she had received the allegation from the resident's family member. The SW stated she had not identified the allegation as being abuse. However, the SW stated after looking at it again, it was an allegation of abuse and should have been reported to the appropriate state/licensing agencies. The SW stated she as well as the DON, ADON, Assistant Administrator, and the Administrator was responsible for notifying the licensing agencies with any allegation of abuse.</p> <p>An interview conducted with the DON on 10/10/12</p>	F 225	<p>Abuse Prevention and Protection Policy will be reviewed and updated to include the Elder Abuse Reporting Requirements.</p> <p>Both the initial report and investigation are now made utilizing two (2) separate forms for allegations of abuse, neglect and misappropriation of resident property.</p> <p>4. As part of CQI a Grievance committee was formed on October 11, 2012. Deborah Fitzpatrick, Administrator is the Chairman of that committee. In addition to the Administrator other members include various Department Managers and the Assistant Administrator. See attachment #1.</p> <p>The Grievance Committee will review all reports of abuse, neglect, mistreatment, injuries of unknown source and theft and misappropriation of resident property during the regularly scheduled meetings. Reviews will be made to determine if policies procedures or facility systems need to be modified to prevent further incidents of abuse or theft.</p> <p>The Grievance Committee will review monthly as part of CQI the trends identified for the potential abuse, neglect and misappropriation of resident property. Criteria for trending review may include but is not limited to staffing, time of day, location within the facility, shift, type of injury, type of patient and treatment administered.</p>		

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F 225	<p>Continued From page 11</p> <p>at 11:50 AM, revealed she was aware of Resident B's allegation and stated the allegation should have been reported to the appropriate state/licensing agency and acknowledged she had failed to report the allegation.</p> <p>4. A review of a facility grievance/complaint form dated 04/30/12 revealed Resident C reported to SW #1 an allegation of physical abuse. The facility investigated the allegation and determined the allegation to be unsubstantiated on 05/01/12. However, the facility failed to notify the appropriate licensing agencies of the allegation of abuse.</p> <p>An interview with SW #1 on 10/10/12 at 10:00 AM, revealed she had received the allegation from the resident. The SW stated she had reported the allegation to the DON. The SW stated she had not notified the appropriate licensing agencies and should have.</p> <p>An interview conducted with the DON on 10/10/12 at 11:50 AM, revealed she had failed to notify the appropriate licensing agencies upon learning of the allegation reported by Resident C and stated she should have.</p> <p>5. A review of a facility grievance/complaint form dated 07/05/12 revealed Resident D's family member reported to SW #1 an allegation of verbal abuse. The facility investigated the allegation and determined the allegation to be unsubstantiated on 07/06/12. However, the facility failed to notify the appropriate state agencies of the allegation of abuse.</p> <p>An interview conducted with SW #1 on 10/10/12</p>	F 225	<p>The facility is currently interviewing 8 residents per month related to care and treatment by staff. This will be increased to 12 residents per week. This will be completed by Social Services. This will be completed for 6 months and re-evaluated at that time. All allegations of abuse, neglect and misappropriation of resident property will be reported to the appropriate state agencies and the investigation will be reported to the State survey agency within 5 working days.</p> <p>Allegations of abuse, neglect and misappropriation, the reporting to state agencies and the investigation will be reported quarterly through CQI by Emily Jones Gray and to the Medical Director as part of CQI.</p> <p>5. Date of Completion is 11/24/12</p> <p>F 490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>It is the policy of this facility that it must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This is evidenced by the following:</p> <p>1. The facility Administrator reviewed the allegations and investigations referred to in</p>		

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F 225	Continued From page 12 at 10:05 AM, revealed she had received the allegation from the family member of Resident D. The SW stated she had not viewed the allegation as being abuse but after reviewing the allegation again felt it was an allegation of abuse and should have been reported to the appropriate state/licensing agencies. The SW did not know why she had not notified the state/licensing agencies. The SW stated she had reported the allegation to the ADON because the DON had been on vacation. An interview conducted with the ADON on 10/10/12 at 11:20 AM, revealed she had been notified of the allegation by the family of Resident D by the SW. The ADON stated she had investigated the allegation and found it to be unsubstantiated but failed to notify the state agencies of the resident's complaint, and acknowledged the allegation should have been reported. An interview conducted with the Administrator on 10/10/12 at 12:20 PM, revealed she had not been aware of the allegations Residents A, B, C, and D had made and acknowledged the facility had failed to ensure the allegations were thoroughly investigated and reported to state agencies as required. In addition, the Administrator acknowledged the facility failed to ensure facility residents were protected during the facility's investigation.	F 225	the statement of deficiencies related to Resident #1, A, B, C, and D. The initial complaint and the investigation for Resident #1, A, B, C, D will be sent to the State and APS. The current facility residents identified during the survey as being affected by the alleged deficient practice were interviewed (as well as their respective family members) by Kathy Meadows, Social Services on 10/16/2012 regarding previous grievances/complaints and any new grievances and complaints. The findings were reported to the Administrator. No new grievances/complaints related to abuse, neglect or misappropriation was identified. 2. Kathy Meadows, Social Services interviewed all interviewable residents in the facility to determine if residents have other complaints/grievances unrelated to call lights. This was completed on 10/16/12 and 10/17/12 The findings were reported to the facility Administrator and the Grievance Committee. The families of all residents that were not interviewed will be contacted to determine if they have grievances related to the care or services their family member receives. This will be completed by Kathy Meadows, Social Services. The findings will be reported to the facility Administrator and the Grievance Committee.		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 490			

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F 490	<p>Continued From page 13</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of facility policy the facility failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of four sampled residents (Resident #1) and four of four unsampled residents (Residents A, B, C, and D). Interview and record review revealed Resident #1 and Residents A, B, C, and D made allegations of abuse to facility staff, however, the facility's administrative staff failed to thoroughly investigate, and failed to ensure facility residents were protected while the allegations of abuse were being investigated. Further interview and record review revealed the facility's administrative staff failed to report allegations of abuse to the appropriate licensing agencies as required.</p> <p>The findings include:</p> <p>A review of the facility policy titled Resident Protection Policy, last reviewed 09/25/12, revealed the Administrator or the Director of Nursing (DON) would immediately report allegations of mistreatment, abuse, or neglect, and misappropriation of property, to the Division of Licensing and Regulation, Adult Protective Services, and other agencies as appropriate. The policy also revealed employees accused of participating in the alleged abuse would be suspended until the findings of the investigation</p>	F 490	<p>Any grievance/complaint (identified during these interviews) related to abuse, neglect or misappropriation of resident property will be reported to the Administrator/designated representative and the appropriate state agencies according to facility policy.</p> <p>The investigations of any grievance/complaints related to abuse, neglect or misappropriation of resident property (as a result of the interviews) will be reported to the Administrator or his/her designated representative and the State survey and certification within 5 working days.</p> <p>3. A grievance committee was formed on October 11, 2012 by Deborah Fitzpatrick, Administrator. The facility Administrator, Deborah Fitzpatrick will be the Chairman of the committee. In addition to the Administrator other members include various Department Managers and the Assistant Administrator. See attachment #1.</p> <p>The Administrator in-serviced all department managers/supervisors concerning the reporting of all allegations to the facility Administrator. See attachment #10.</p> <p>All committee members were given copies (by the facility Administrator) of the regulation related to abuse reporting and current facility policy regarding resident protection. The current facility policy will be</p>	

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F 490	<p>Continued From page 14</p> <p>had been reviewed by the Administrator. According to the policy, allegations of abuse would be promptly and thoroughly investigated. The policy also revealed the Administrator would provide the person in charge of the investigation a copy of the Incident Report Form and any supported documentation relative to the investigation.</p> <p>1. A review of the facility's investigation of an allegation of abuse voiced by a resident revealed another resident, Resident #1, had also notified the DON of an allegation of abuse that involved Certified Nurse Aide (CNA) #15 on 09/26/12. Further review of the investigation revealed no evidence the allegation made by Resident #1 had been thoroughly investigated or reported to state agencies as required.</p> <p>An interview with CNA #15 on 10/09/12 at 11:30 AM, revealed she was not aware of an allegation of abuse which involved Resident #1. The CNA stated facility staff had not notified her that Resident #1 had voiced an allegation of abuse against her.</p> <p>An interview with the DON on 10/09/12 at 8:30 AM, confirmed she had received an allegation of abuse from Resident #1 on 09/26/12, which involved CNA #15. Further interview revealed the allegation was not reported to state agencies as required, and the Resident Abuse Investigation Report Form, as stated in the facility policy, was not utilized for the resident's allegation of abuse. The DON stated the incident was not reported because the CNA involved had already been suspended related to another ongoing investigation of alleged abuse. Further interview</p>	F 490	<p>reviewed and revised to include the Elder Abuse Reporting requirements:</p> <p>All complaints regarding allegations of abuse, neglect and misappropriation of resident property will be reviewed in the weekly Grievance committee meeting.</p> <p>All grievances/complaints related to abuse, neglect or misappropriation of resident property will be reported to the Administrator/designated representative and the appropriate state agencies according to facility policy utilizing the new initial report form.</p> <p>The investigations of any grievance/complaints related to abuse, neglect or misappropriation of resident property will be reported to the Administrator or his/her designated representative and the State survey and certification within 5 working days utilizing the new investigation form.</p> <p>The reporting forms were reviewed and both the initial report and investigation are now made utilizing two (2) separate forms for allegations of abuse, neglect and misappropriation of resident property.</p> <p>4. As part of CQI a Grievance committee was formed on October 11, 2012. Deborah Fitzpatrick, Administrator is the Chairman of that committee. In addition to the Administrator other members include various</p>		

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F 490	<p>Continued From page 15</p> <p>revealed the allegation of abuse which involved Resident #1 was investigated with the current investigation in progress. The DON stated the allegation of abuse voiced by Resident #1 should have been reported to state agencies as required, and the appropriate form should have been utilized as an investigation tool, as stated in the facility's policy.</p> <p>The Administrator acknowledged in interview on 10/10/12 at 12:20 PM, she had failed to ensure all allegations were reported to the appropriate state agencies as required, all allegations of abuse were thoroughly investigated, or that the facility's residents were protected during the investigations. The Administrator stated she was aware of Resident #1's allegation of abuse voiced to the DON but failed to ensure the allegation was thoroughly investigated and reported as required.</p> <p>2. A review of a facility grievance/complaint form dated 04/10/12 revealed Resident A's family reported to SW #2 an allegation of sexual abuse. The facility investigated the allegation and determined the allegation to be unsubstantiated on 04/11/12. However, the facility failed to notify the appropriate state/licensing agencies.</p> <p>An interview conducted with SW #2 on 10/10/12 at 9:15 AM, revealed she had received the allegation from the family member of Resident A and had reported the allegation to the DON for investigation. The SW stated she had written the allegation on a grievance/complaint form and that she, the DON, the Assistant Director of Nursing (ADON), or the Administrator was responsible for notifying the appropriate state/licensing agencies. The SW stated she should have called the</p>	F 490	<p>Department Managers and the Assistant Administrator. See attachment #1.</p> <p>The Grievance Committee will review all reports of abuse, neglect, mistreatment, injuries of unknown source and theft and misappropriation of resident property during the regularly scheduled meetings. Reviews will be made to determine if policies procedures or facility systems need to be modified to prevent further incidents of abuse or theft.</p> <p>The Grievance Committee will review monthly as part of CQI the trends identified for the potential abuse, neglect and misappropriation of resident property. Criteria for trending review may include but is not limited to staffing, time of day, location within the facility, shift, type of injury, type of patient and treatment administered.</p> <p>The facility is currently interviewing 8 residents per month related to care and treatment by staff. This will be increased to 12 residents per week. All allegations of abuse, neglect and misappropriation of resident property will be reported to the Administrator or designated representative and to the appropriate state agencies and the investigation will be reported to the State survey agency within 5 working days. This will be monitored through the Grievance Committee. This will be ongoing.</p>	

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F 490	<p>Continued From page 16</p> <p>licensing agencies and was unsure why she had not.</p> <p>An interview conducted with the DON on 10/10/12 at 11:50 AM, revealed the allegation had been reported to her by SW #2; she initiated an investigation and stated the allegation had been found to be unsubstantiated. However, the DON stated the allegation was not reported to the state/licensing agencies and acknowledged she should have. Further interview revealed the Resident Abuse Investigation Report Form had not been utilized for the allegation of abuse.</p> <p>3. A review of a facility grievance/complaint form dated 04/16/12 revealed Resident B's family reported to SW #1 an allegation of verbal abuse. The facility investigated the allegation and determined the allegation to be unsubstantiated on 04/23/12. However, the facility failed to notify the appropriate licensing agencies of the allegation of abuse.</p> <p>An interview conducted with SW #1 on 10/10/12 at 9:50 AM, revealed she had received the allegation from the resident's family member. The SW stated she had not identified the allegation as being abuse. However, the SW stated after looking at the allegation again it should have been reported to the appropriate state/licensing agencies. The SW stated she was unsure why she had not notified the licensing agencies.</p> <p>An interview conducted with the DON on 10/10/12 at 11:50 AM, revealed she was aware of the incident and should have notified the licensing agencies and failed to do so.</p>	F 490	<p>Allegations of abuse, neglect and misappropriation, the reporting to the Administrator, state agencies and reporting of the investigation to State survey agency will be reported quarterly through CQI by Emily Jones Gray and to the Medical Director as part of CQI.</p> <p>5. Date of Completion is 11/24/12</p> <p>F 520 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>It is the policy of this facility to maintain a quality assessment and assurance committee that meets quarterly to identify issues and to develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>1. Resident I was discharged to home on 10/12/2012.</p> <p>Resident E, F, G and H was interviewed by Kathy Meadows, Social Services on 11/5/2012 to determine if there are other grievances unrelated to call lights.</p> <p>Any identified grievances will be investigated by the respective department head and the residents will be notified of the resolution by the department head or Kathy Meadows, Social Services.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 490	Continued From page 17 4. A review of a facility grievance/complaint form dated 04/30/12 revealed Resident C reported to SW #1 an allegation of physical abuse. The facility investigated the allegation and determined the allegation to be unsubstantiated on 05/01/12. However, the facility failed to notify the appropriate state agencies of the allegation of abuse. An interview with SW #1 on 10/10/12 at 10:00 AM, revealed she had received the allegation from the resident. The SW stated she had reported the allegation to the DON. The SW stated she had not notified the appropriate licensing agencies and should have and was unsure why she had not. An interview conducted with the DON on 10/10/12 at 11:50 AM, revealed she had failed to notify the appropriate state/licensing agencies of the allegation of abuse. 5. A review of a facility grievance/complaint form dated 07/05/12 revealed Resident D's family member reported to SW #1 an allegation of verbal abuse. The facility investigated the allegation and determined the allegation to be unsubstantiated on 07/06/12. However, the facility failed to notify the appropriate state/licensing agencies of the allegation of abuse. An interview conducted with SW #1 on 10/10/12 at 10:05 AM, revealed she had received the allegation from the family member of Resident D and had not initially viewed the allegation as abuse. According to SW #1, after reviewing the	F 490	Residents E, F, G, and H will be interviewed weekly for 3 months to determine if call lights are being answered timely or if they have other grievances unrelated to call lights. This will be completed by Kathy Meadows or Misty Pennington, Social Services. Any grievance identified during the weekly interview (for any of these residents) will be investigated by the respective department head and the respective residents will be informed of the investigation and plans to resolve the grievance by the department head, Kathy Meadows or Misty Pennington, Social Services. Any/all grievances identified during this interview process will be reported to the facility Administrator by the person completing the interview/grievance form and will be reviewed at the next grievance committee meeting. 2. As a result of this being a complaint through resident council, all residents have been identified as having the potential to be affected as it relates to call lights. Kathy Meadows, Social Services interviewed all interviewable residents in the facility to determine if residents have other complaints/grievances unrelated to call lights. This was completed on 10/16/12 and 10/17/12.		

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F 490	<p>Continued From page 18</p> <p>allegation a second time, the resident's allegation appeared to be an allegation of abuse and should have been reported to the appropriate state/licensing agencies. The SW stated she reported the allegation to the ADON because the DON was on vacation.</p> <p>An interview conducted with the ADON on 10/10/12 at 11:20 AM, acknowledged the SW had informed her of an allegation of abuse voiced by the family of Resident D. The ADON stated she had investigated the allegation and found it to be unsubstantiated but stated she failed to notify the state agencies of the allegation.</p> <p>The Administrator acknowledged in interview conducted on 10/10/12 at 12:20 PM, that she had failed to ensure all allegations of abuse had been thoroughly investigated, that facility residents were protected during the investigations, and failed to ensure all allegations were reported to the appropriate state agencies as required. The Administrator stated she had not been aware of the allegations of abuse for Resident A, Resident B, Resident C, and Resident D.</p>	F 490	<p>The families of all residents that were not interviewed will be contacted to determine if they have grievances related to the care or services their family member receives. This will be completed by Kathy Meadows, Social Services.</p> <p>All grievances or complaints identified during either resident or family interviews will be reported to the facility Administrator by Kathy Meadows, Social Services and will be investigated by the respective department manager.</p> <p>Any grievance/complaint (identified during these interviews) related to abuse, neglect or misappropriation of resident property will be reported to the appropriate state agencies according to facility policy.</p> <p>The results of the investigation and the plan to resolve or the resolution will be reported to the respective resident or family member by either the person investigating and involved in the resolution or Kathy Meadows or Misty Pennington Social Services.</p>	
F 520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify</p>	F 520	<p>All grievances/complaints identified during these interviews will be discusses in the grievance committee meeting and will include the grievance and investigation, resolution, satisfaction of resident/family with resolution, any further action to prevent a reoccurrence and reporting to appropriate state agencies if applicable.</p>	

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F 520	<p>Continued From page 19</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined the facility failed to ensure the Quality Assessment and Assurance Committee was effective to ensure staff responded to call lights in a timely manner. A review of Resident Council meeting minutes for nine of the most recent ten months (January, February, April, May, June, July, August, September, and October 2012) revealed residents expressed concerns related to call lights not always being answered timely. However, there was no evidence the facility identified issues with respect to which quality assessment and assurance activities were necessary in order to resolve resident grievances or to ensure residents were informed of any actions taken. (Refer to F166.)</p> <p>The findings include:</p>	F 520	<p>3. A grievance committee was formed on October 11, 2012 by Deborah Fitzpatrick, Administrator. In addition to the Administrator other members include various Department Managers and the Assistant Administrator. See attachment #1.</p> <p>On October 16, 2012 the following policies were revised and finalized by the grievance committee. See attachment #2, #3 and #4: Filing Grievances/Complaints Grievance Complaint Log Grievances/Complaints - Staff Responsibility</p> <p>On October 16, 2012 a new Complaint/Grievance Report Form was adopted which includes filing and investigation of grievances or complaints, resolution, satisfaction with resolution and reporting of investigation and resolution. See attachment #5.</p> <p>On October 16, 2012 a new Grievance Complaint Log was adopted for tracking grievances and complaints. See attachment #6.</p> <p>On October 16, 2012 a separate Resident Council Departmental Response Form was adopted for investigation of complaints through resident council and resolution of complaints. See attachment #7.</p> <p>All staff will be in-serviced on the new facility policies regarding</p>	

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F 520	<p>Continued From page 20</p> <p>A review of the facility's policy titled "Quality Control," which contained no date, revealed the facility had developed a quality control program which identified specific deficiencies, measured the level of quality services by the departments, and continually furnished information that would aid the facility in taking corrective action. In addition, the policy revealed quality control records would be maintained and would be discussed quarterly during committee meetings. The policy also stated any items requiring corrective action would be discussed with the Administrator as they arose.</p> <p>A group interview was conducted with five alert/oriented residents (Residents E, F, G, H, and I) on 10/09/12 at 9:30 AM. The residents complained staff does not always respond to call lights timely. The residents revealed there was no particular shift involved and this occurred on all shifts. Residents confirmed they had made the facility aware of the complaints; however, they had never received a response from the facility.</p> <p>A review of the Resident Council minutes dated 01/03/12, 02/07/12, 04/03/12, 05/01/12, 06/05/12, 07/03/12, 08/07/12, 09/04/12, and 10/02/12 confirmed residents had expressed their concerns to the facility during the monthly Resident Council meetings related to staff's failure to respond to resident call lights in a timely manner.</p> <p>An interview conducted with Social Worker (SW)#1 on 10/09/12 at 10:30 AM, revealed she attended the Resident Council meetings and was responsible for completing grievance forms for all</p>	F 520	<p>complaints/grievances, the new forms and where these policies and forms will be kept for easy access for staff. This will be completed by Administrative Staff and Social Services.</p> <p>The new grievance and complaint forms will be placed at each nursing station and all other departments by Kathy Meadows, Social Services and Misty Pennington, Social Services.</p> <p>The new/revised policies will be kept at each nursing station and all other departments for easy access by staff.</p> <p>The time and date of the resident council meeting will be changed (with the permission of resident council) to a time that will allow both Social Workers and more residents to participate in resident council. This will be discussed in the next resident council meeting (Scheduled for 11/6/2012) by Kathy Meadows and Misty Pennington, Social Services.</p> <p>Activities staff will remind residents the day before resident council to encourage more participation.</p> <p>The Resident Council President will be notified of any resolutions to grievances identified in the previous resident council meeting.</p>		

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F 520	<p>Continued From page 21</p> <p>the complaints/grievances she received at the Resident Council meetings, and providing a copy of the form to the pertinent Department Managers to address. According to the SW, the Department Managers were required to address the issue, document their responses on the form, and return the completed form to the SW who then was responsible to log and file the complaint/grievance. The SW also stated the grievances were to then be reviewed by the Administrator. In addition, the SW stated the Department Managers were responsible to notify the residents of the outcome of the grievance/complaint. SW #1 stated she had previously spoken with the Administrator and the Director of Nursing (DON) regarding the residents' complaints that staff failed to respond to resident call lights in a timely manner, but could not recall the date, and was unaware of what had been done to correct or resolve the issue. The SW stated grievances were reviewed by the Quality Assurance Committee.</p> <p>An interview conducted with the DON on 10/10/12 at 11:50 AM, revealed she had been aware of the grievances/complaints made by the residents regarding call lights not being answered in a timely manner. The DON stated she had provided in-services to the nursing staff and she, the Assistant Administrator (AA), and facility staff had assessed the length of time it took for staff to answer call lights. The DON stated she was not aware the residents had continued to complain of staff response to call lights. The DON stated the Quality Assurance Committee had monitored the problem with staff not responding to the call lights timely, and added that the Committee had failed to develop an effective plan of action.</p>	F 520	<p>The Resident Council President will be invited to attend the facility Grievance Committee meeting to review the grievance and the resolution.</p> <p>The resident expectation of a reasonable time for a call light to be answered will be discussed in resident council. Kathy Meadows and Misty Pennington Social Services will complete this.</p> <p>Staff in-servicing regarding answering of call lights began on 10/12/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. See attachment #8.</p> <p>4. A grievance committee was formed (consisting of various department managers, the Administrator and Assistant Administrator) as part of CQI and will meet weekly. The facility Administrator, Deborah Fitzpatrick is Chairman of this committee.</p> <p>The responsibility of the committee is to review all grievances and their investigation, any and all actions taken to resolve the grievance, resident and family satisfaction with the response from the facility and the resolution, and any further actions which may be suggested by the committee to prevent a repeat occurrence. This will be ongoing.</p> <p>As part of CQI, twelve (12) residents will be interviewed weekly to determine if call lights are being answered timely and if residents have other grievances/complaints. This will</p>		

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F 520	Continued From page 22 An interview conducted with the AA on 10/10/12 at 2:40 PM, revealed she was also responsible for the Quality Assurance program for the facility. The AA stated the facility had been monitoring staff response to resident call lights on an ongoing basis. The AA stated she had been aware the problem had continued and the facility had not implemented different interventions to ensure the problem was corrected. The AA stated call lights not being answered were being monitored by the Quality Assurance Committee; however, the AA stated the Committee had failed to develop an effective plan of action to ensure staff responded to resident call lights when the current plan failed. An interview conducted with the Administrator on 10/10/12 at 2:50 PM, revealed the Administrator had not been aware of the continuing grievances/complaints raised by residents at the monthly Resident Council meeting regarding call lights not being answered in a timely manner. The Administrator stated Department Managers were required to follow up with the residents regarding resolutions to grievances/complaints and interventions put into place by the facility, and added the DON was responsible to follow up with the Resident Council. The Administrator stated she was responsible for reviewing all grievances; however, the grievances regarding the call lights had not been forwarded to her, and any grievance/complaint that arose would be addressed by the DON again in order for a new plan to be established. The Administrator stated the Quality Assurance Committee monitored staff response to call lights; however, the Administrator stated the Committee had failed to develop a plan	F 520	be completed by Kathy Meadows and Misty Pennington, Social Services and Marie Pennington, Activity Director. This will be completed for 6 months and re-evaluated at that time. All grievances/ complaints will be reported quarterly through CQI by Emily Jones Gray, Assistant Administrator. The Medical Director is part of the CQI team and will be informed during CQI of the findings. As part of CQI a room inspection was completed on October 15, 2012 by Kitty Harmon, Housekeeping/Laundry Supervisor. Proper placement of call lights was part of this audit. As a continued monitoring for proper placement of call lights (to ensure that call lights are in reach of residents) housekeeping will document daily the position of the call lights when they are in the resident rooms. If call lights are not in reach of the resident the housekeeping employee should place the call light in reach of the resident and document where the call light was. She should then report this to the nurse. This will be ongoing. The Housekeeping Supervisor will review the call light logs weekly to determine if there are patterns in particular residents call lights. These finding will be reported to the Director of Nursing for resolution and will also be reported weekly in the Grievance Committee	

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F 520	Continued From page 23 of action when the plan currently used was not effective.	F 520	<p>and quarterly through CQI by Emily Jones Gray. This will be ongoing.</p> <p>Twelve (12) Random call light checks will be completed weekly to determine if call lights are being answered timely. This will be completed by various staff assigned by the department managers. This will be done for 3 months at a minimum and will be re-evaluated by the Grievance Committee.</p> <p>A walk through of each nursing unit will be completed at a minimum of 3 days per week by various department managers. The walk through will include appearance of room/bathroom/resident and location of call light. During this walk through each resident will be asked specifically if they have any issues with staff responding to their call light. The results of these audits will be reported weekly in the Grievance committee and quarterly through CQI by Emily Jones Gray. This will be completed for 6 months and will be re-evaluated by the Grievance Committee.</p> <p>5. Date of Completion is 11/24/12</p>		