

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>A Recertification Survey/Extended Survey was initiated on 06/30/14 and concluded on 07/03/14. Immediate Jeopardy was identified on 06/30/14 and was determined to exist on 06/24/14, in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care (F-323). The facility was notified of the Immediate Jeopardy on 06/30/14.</p> <p>The facility failed to ensure the residents' environment remained as free of accidental hazards as was possible, failed to ensure the facility's evacuation plan was updated to reflect necessary changes to fire exits related to construction, and failed to ensure all staff was trained and knowledgeable regarding which fire exits were appropriate for evacuation during the construction. On 06/24/14, the facility began construction by removing the concrete pavement outside the Northwest hallway exit and the Dining room exit, and on 06/27/14 the Southwest exit door had pavement removed, affecting the safe path to a public way for three (3) of the facility's eight (8) exits, which the facility had detailed as fire evacuation exits.</p> <p>Observation on 06/30/14 revealed the fire exit located at the end of the Northwest hallway had a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar (common steel bar used in construction to reinforce concrete); the fire exit located at the Dining room exit had a</p>	F 000	<p><i>Acronym Master List</i></p> <p>AA Administrative Assistant</p> <p>ABOM Assistant Business Office Manager</p> <p>ADON Assistant Director of Nursing</p> <p>BOM Business Office Manager</p> <p>CRS Clinical Reimbursement Specialist</p> <p>DOA Director of Admissions</p> <p>DON Director of Nursing</p> <p>DSM Dietary Services Manager</p> <p>ESD Environmental Services Manager</p> <p>ESNS Evening Shift Nurse Supervisor</p> <p>HRD/AIT HR Director/Administrator in Training</p> <p>MDSN MDS Nurse</p> <p>MOD Manager on Duty</p> <p>MRM Medical Records Manager</p> <p>POA Power of Attorney</p> <p>POD Plant Operations Director</p> <p>PODA Plant Operations Director Assistant</p> <p>QA Quality Assurance</p> <p>QoLA Quality of Life Assistant</p> <p>QoLD Quality of Life Director</p> <p>RSM Rehab Services Manager</p> <p>SCC Signature Care Consultant</p> <p>SDC Staff Development Director</p> <p>SSD Social Services Director</p> <p>WCN Wound Care Nurse</p> <p>WNS Weekend Nurse Supervisor</p>	

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

TITLE

(X8) DATE

[Signature]

ADMINISTRATOR

*AMENDED x2
10/13/2014*

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	<p>Continued From page 1</p> <p>concrete pad leading to a three and a half (3.5) inch drop off to gravel and rebar, and, the Southwest hallway had a ramp which led to a four and a half (4.5) inch drop off with gravel. Observation revealed there was no signage posted at the Northwest, Dining room, and Southwest exits to alert staff, resident, and visitors these exits were not accessible due to the construction. In addition, observation revealed no posting of new evacuation routes in case of fire or other emergencies due to the exits not being accessible related to the construction. Staff interviews revealed, in the event of an emergency, they would have evacuated residents through the Northwest, Dining room, and Southwest exits as they were not aware of any changes in the facility's evacuation plan.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14 with remaining non-compliance in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) at a Scope and Severity of a "E" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. KY00021980 was unsubstantiated with no related deficiencies cited. Immediate Jeopardy was identified on 07/25/14 and was</p>	F 000	<p><i>QA Committee Members (but not limited to) Administrator, DON, Medical Director, ADON, SDC, HRD/AIT, DOA, MDSN, MRM, DSM, ESD, POD, BOM, QoLD and SSD.</i></p>		

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F 000	<p>Continued From page 2</p> <p>determined to exist on 07/03/14, in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K". Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of the Immediate Jeopardy on 07/25/14.</p> <p>On 07/03/14, Resident #26 rang the call bell for incontinence care assistance at approximately 5:30 AM; however was not assisted until approximately 7:45 AM, (two hours and fifteen minutes later). Interview with the day shift State Registered Nursing Assistant (SRNA), who assisted Resident #26 at 7:45 AM, revealed the resident was soaked with urine and covered in bowel movement. Staff interviews further revealed four (4) other residents were also left soaked in urine or soiled with bowel movement the morning of 07/03/14, after day shift reported to work at 7:00 AM. According to staff interview there was a conflict between SRNA #19 and SRNA #21, who worked on the South Unit during the night shift, and they did not work together. Staff interviews revealed they were aware of the the conflict between the SRNAs; however, interviews with Administrative staff revealed they were not aware and had not taken action which negatively impacted resident care on the South Unit on 07/03/14. The facility failed to conduct a thorough investigation to include assessments of those residents involved; skin assessments of non-interviewable residents cared for the SRNA #19; and, interviews with all staff who had knowledge of the incident. Additionally, interviews with residents revealed call lights were</p>	F 000		
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F 000	Continued From page 3 not answered timely and their request for assistance was not provided timely due to the facility's staffing. Also, interviews with staff revealed the facility was short staffed on night shift and the staff could not always meet the residents' needs and/or answer call lights in a timely manner. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) at a Scope and Severity of a "E" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes. In addition, deficient practice was identified during the Recertification Survey at: 42 CFR 483.10 Resident Rights (F-166) at a S/S of an "E"; 42 CFR 483.20 Resident Assessment (F-276 and F-278) at a S/S of a "D", (F-279 and F-280) at a S/S of an "E", (F-281) at a S/S of a "D", and (F-282) at a S/S of a "G"; 42 CFR 483.25 Quality of Care (F-309) at a S/S of an "G" and (F-315) at a S/S of a "D"; 42 CFR 483.35 Dietary Services (F-371) at a S/S of an "F"; and 42 CFR 483.65 Infection Control (F-441) at a S/S of a "D".	F 000			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166			

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F 166	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, resident council group interview, review of the facility's policy and procedures, review of facility resident questionnaires, and the Resident Council Minutes it was determined the facility failed to ensure attempts were made to resolve grievances for nine (9) of thirty-seven (37) sampled residents (Residents #8, #14, #16, #17, #24, #32, #33, #35, #36) and three (3) unsampled residents (Unsampled Residents C, D, E). Review of the Resident Council Minutes, dated April, May, June, and July 2014, revealed the residents had complained, of their call bells not being answered timely in the past two (2) months. Interview with Residents #14, #17, #24, #33, #36 and Unsampled Residents C, D, and E during the Group Interview and also individual resident interviews revealed they continued to complain of their call bells not being answered timely. However, review of the facility's documentation regarding grievance forms and call light audits revealed no documented evidence the facility had attempted to resolve the residents' grievances regarding call bells, even though this had been an ongoing concern expressed by residents since April 2014.</p> <p>In addition, during the facility's investigation regarding alleged neglect, eight (8) interviewable residents were interviewed by facility staff (Residents #8, #16, #17, #24, #32, #33, #35 and</p>	F 166	<p>F166</p> <p>Immediate Corrective Action for Residents Found To Be Affected</p> <ul style="list-style-type: none"> Resident #8, 14, 16, 17, 24, 32, 33, 36, and three un-sampled residents C, D, and E have all had grievances completed with Resident #24 having an updated pain assessment and care plan completed July 23 to July 25, 2014 by SSD, Administrator, DON, MRM, QoLA, ESD, DOA, MDSN, HRD/AIT and QoLD to include follow-up and resolution reported to all appropriate state agencies. Resident #35 discharged from the facility on July 10, 2014. <p>Identification of Other Residents with the Potential to be affected</p> <ul style="list-style-type: none"> All residents with BIMs of 8 or above were interviewed on July 23 to July 25, 2014 by SSD, HRD/AIT, QoLD, QoLA, MRM, Chaplain, BOM, DOA, ADON, SDC, SCC and ESNS with any concerns voiced taken through the grievance process for follow-up and resolution. All residents with a BIMS below 8, Responsible Parties, POA or Guardian were interviewed on July 23 to August 04, 2014 by SSD, HRD/AIT, DOA, MRM, Chaplain, BOM, ABOM, ESD, DSM, SCC, ADON, QoLA and QoLD with any concerns taken through the grievance process for follow-up and resolution. Anyone unable to contact were sent certified letters on July 29, 2014. 		

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F 166	<p>Continued From page 5</p> <p>#36). All eight (8) residents verbalized concerns regarding night shift staff's care, which was documented on the facility's "care questionnaire" forms utilized during the interviews. The residents expressed concerns related to: problems with their call light not being answered in a timely manner; having to wait for extended periods of time to receive the care requested; not getting their medication as ordered; and not receiving pain medications as ordered or requested. Although the facility's investigation identified those eight (8) residents' concerns regarding care issues, there was no documented evidence the facility investigated and followed-up on the concerns to resolve the residents' grievances.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Investigating a Resident Grievance or Complaint", dated December 2010, revealed it was the intent of the facility for all grievances and/or complaints to be investigated by the appropriate facility staff and recorded on the grievance/complaint log. Policy review revealed the Administrator would assign the responsibility of investigating grievances and complaints to the Social Services Director (SSD) or designee. According to the policy, all grievances/complaints would be documented on the Grievance and Complaint Report by the person receiving the report, and the SSD or designee would begin an investigation into the allegations. The policy revealed the investigation and report were to include a follow-up/recommendation for corrective action, a resolution, and date of the resolution. Continued review of the policy revealed the Grievance/Complaint Investigation Report was to</p>	F 166	<p>Measures taken to assure there will not be a Recurrence</p> <ul style="list-style-type: none"> ◆ All staff will be in serviced on July 23 to July 30, 2014 by the SDC, SCC, HRD/AIT, SSD, ESNS, DON, ADON, WCN, RSM, QoLD, QoLA, BOM, Assistant BOM (ABOM), Administrative Assistant (AA), MRM, DSM, ESD, POD, DOA, MDSN, Weekend Nurse Supervisor (WNS), SSD or Chaplain related to Grievance policy and procedure. Re-education was initiated on August 25, 2014 and was completed by September 12, 2014. ◆ Education has been provided by the SCC on July 23 to July 28, 2014 to all department heads related to following the grievance policy and procedure and assuring all concerns are investigated and follow-up is completed timely. ◆ Any staff member not receiving the education by September 12, 2014 will not be allowed to work a shift until the education has been provided by the SDC, SCC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain. 		

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F 166	<p>Continued From page 6</p> <p>be reviewed by the Administrator within three (3) working days of the receipt of the grievances or complaint and the resident or person acting on behalf of the resident was to be informed of the findings upon completion of the investigation, as well as, any corrective actions. Further review revealed the grievance or complaint and the corrective action taken were to be documented in the Social Service Progress Notes in the resident's medical record, on the Grievance Complaint Form and noted on the grievance/complaint log. The completed Grievance/Complaint Form was to be maintained on file in the Administrator's office or SSD's office.</p> <p>Review of Resident Council Meeting Notes dated 04/28/14 and 05/20/14, revealed call lights were not being answered promptly and were not being answered around 10:00 PM to 11:00 PM. Further review of the Resident Counsel Meeting Notes, date 07/14/14, revealed residents were hearing personal conversations among State Registered Nursing Assistants (SRNAs) instead of answering call lights, and staff was responding to call lights, but turning the call light off without addressing what the resident's needed.</p> <p>Review of the facility's information regarding complaints/grievances revealed no documented evidence call light concerns were addressed until 06/03/14. Review of the Complaint/Grievance Report form dated 06/03/14, revealed the Resident Council's concerns were addressed by the SSD, and the SSD documented she, along with nursing staff, would audit call lights across all shifts. Further review of the Complaint/Grievance form dated 06/03/14, revealed the resolution, which was undated, noted the facility would continue call light audits until further notice.</p>	F 166	<ul style="list-style-type: none"> ◆ Beginning September 12, 2014 Residents and families attending care plan conferences shall be asked by the SSD, MDSN, QoLD or Licensed Nurse if there have been any concerns and if grievance process has been initiated and followed. If resident or responsible party does not attend the care plan conference the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain. shall attempt to contact via phone x3 for response. ◆ The Administrator will be responsible for monitoring the grievance process to be assured all grievances have been completed per the policy and procedure. ◆ Beginning August 02, 2014, five audits are being completed daily across all shifts by SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, Administrator, Chaplain or Licensed Nurse related to call light observations to assure answered timely and patient care needs met. This will be ongoing until instructed otherwise by QA Committee. 		

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F 166	Continued From page 7 Review of the facility's call light audits for June 2014 revealed audits were conducted on two (2) shifts, the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts. However, further review of the call light audits revealed there was no documented evidence the audits were conducted on the 11:00 PM to 7:00 AM shift. 1. Interview with residents during the Group Interview conducted on 07/01/14 at 10:50 AM by the State Survey Agency, revealed Resident #14, Resident #17, Resident #24, Resident #33, Resident #36, Unsampled Resident C, Unsampled Resident D, and Unsampled Resident E were present. The residents present stated they have had to wait for an hour or longer for staff to answer their call lights. The residents in the Group Interview stated they were not certain their concern regarding staff answering their call lights in a timely manner was addressed by the facility, even though they had voiced their concern in Resident Council Meetings. Interview with Resident #14 on 07/03/14 at 2:00 PM, revealed the staff were slow to answer the call lights on the weekends. Interview, on 07/01/14 at 11:00 AM, with Resident #17 during the Group Interview revealed he/she had waited for over an hour "a lot" of times for someone to come and assist him/her after ringing his/her call light. According to Resident #17, staff who were not SRNA's turned off his/her call light and walked away without assisting him/her, or getting someone else to provide assistance. Review of Resident #17's Quarterly Minimum Data Set (MDS) dated 06/23/14, revealed the facility assessed Resident #17 to have a Brief	F 166	<ul style="list-style-type: none"> ◆ Beginning August 02, 2014 five resident interviews daily of residents with BIMS of 8 or above by the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator, Chaplain or Weekend Manager on Duty (MOD) to address call lights and any care issues. This will be ongoing until instructed otherwise by QA Committee. ◆ SCC educated the SSD on July 24, 2014 relative to responsibility to address complaints and grievances timely with appropriate follow up per company policy and regulatory guidelines. This is to include any complaints from Resident Council. 		

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F 166	<p>Continued From page 8</p> <p>Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact.</p> <p>Interview, on 07/25/14 at 9:30 AM; with Resident #24 revealed she had problems with call lights not being answered timely. Resident #24 stated it could range from five (5) minutes to an hour for staff to answer it. According to Resident #24, he/she knew the staff got "covered up" with work at times, and it might take longer then. Per interview, Resident #24 stated he/she took himself/herself to the bathroom, and did not ask staff for help to do that. Continued interview with Resident #24 revealed he/she had complained of the call light issue before in the past; however, indicated he/she could not recall who he/she told. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #26 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #26 as requiring: extensive physical assistance of two (2) staff with his/her Activities of Daily Living (ADLs) of bed mobility, transfers and toileting.</p> <p>Interview with Resident #33, on 07/03/14 at 2:25 PM, revealed it took staff "a long time" to respond to his/her call light when he/she rang it. Resident #33 reported it was worse at night. Review of the Quarterly MDS Assessment dated 05/15/14 revealed the facility assessed Resident #33 to have a BIMS score of fourteen (14), indicating the resident was cognitively intact.</p> <p>Interview, on 07/24/14 at 2:10 PM, with Resident</p>	F 166	<p>Monitoring Changes to Assure Continuing Compliance</p> <ul style="list-style-type: none"> ◆ <i>The Administrator will be responsible for monitoring the grievance process to be assured all grievances have been completed per the policy and procedure by reviewing each grievance and the grievance log weekly beginning September 22, 2014 until instructed otherwise by the QA Committee.</i> ◆ Beginning August 06, 2014 all audits and observations as well as grievances will be brought to the QA committee weekly x 4 weeks and then monthly ongoing by the SSD in order to track and trend and to provide additional recommendations for ongoing process improvements. <p>Date of Completion: 09-27-14</p>		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 166	<p>Continued From page 9</p> <p>#36 revealed he/she had to wait twenty (20) to thirty (30) minutes "sometimes" for his/her call light to be answered. According to Resident #36, he/she thought the facility was "really short of staff at night"; staff was busy and couldn't get to him/her "right away" at times. Review of the Quarterly MDS Assessment, dated 06/16/14, revealed the facility assessed Resident #36 to have a BIMS score of fourteen (14) which indicated the resident was cognitively intact.</p> <p>Interview with the Activities Director on 07/03/14 at 3:42 PM, revealed residents in the Resident Council Meetings had voiced concerns about staff taking a long time to answer their call lights. She reported, the residents concerns were filled out on a grievance form and given to the SSD who was supposed to "look" into the residents' concerns. The Activities Director stated the facility had seventy-two (72) hours to answer a resident's voiced concern and correct the issues. She stated the resolution of the call lights not being answered by staff was addressed with the SSD who was auditing the call lights across all the shifts.</p> <p>Interview with the SSD on 07/03/14 at 4:08 PM, revealed if a concern was brought up in the Resident Council Meetings, then a grievance/complaint form was filled out. She stated if the concern brought up was about a specific department, then she would let that department know about the concern. Continued interview with the SSD revealed the Resident Council had concerns about the call lights not being answered timely, and she developed an audit for call lights to be performed across all shifts and during shift changes. She indicated the majority of call light audits had been done during</p>	F 166			

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

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F 166	<p>Continued From page 10</p> <p>the day shift, with a "few" audits conducted by nurses and SRNAs during the 3:00 PM to 11:00 PM shift. However, call light audits had not been completed during the SRNAs 11:00 PM till 7:00 AM shifts. The SSD indicated the call light audits should have been performed during the 11:00 PM to 7:00 AM SRNAs shift though, as the audits were supposed to be performed across all shifts.</p> <p>Interview with the Registered Nurse (RN) #4/Assistant Director of Nursing (ADON) of the South Unit, on 07/03/14 at 4:35 PM, revealed the SSD was responsible for the audits of the call lights and it was reviewed in the facility's Quality Assurance (QA) meetings. RN #4/ADON reported the SSD had audited all shifts and stated she did not participate in the auditing of call lights. She stated she was not aware of nursing staff assisting with the call light audits, as to her knowledge only the SSD was auditing the facility's call light system.</p> <p>Interview with the Staff Development Coordinator (SDC), on 07/03/14 at 6:41 PM, revealed the call light audits were used to observe the amount of time it took for staff to respond to a resident's call light after the resident rang the call light. She reported the audits were done on all shifts. However, there was no documented evidence an audit was completed on the 11:00 PM to 7:00 AM shift. Further interview with the SDC revealed all shifts should have been audited for call light concerns, per the Resident Council's concern.</p> <p>Interview with the Director of Nursing (DON), on 07/03/14 at 5:20 PM, revealed the facility talked to the residents once a week to find out about how staff was doing with answering their call lights. She stated if a concern regarding the call</p>	F 166			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 166	<p>Continued From page 11</p> <p>lights came up more often, then she would talk to residents more often related to their concerns. She reported Resident #26 had brought the call light concern of residents having to wait for an hour or more for staff to assist with their care to her attention. The DON stated this was why the facility was continuing with the call light audits. However, there was no evidence the call light audit had been conducted consistently and on all three (3) shifts.</p> <p>Interview with the former Administrator, on 07/03/14 at 7:25 PM, and 07/31/14 at 10:14 PM revealed, she was the Administrator for the facility from 05/15/14 until 07/11/14. The former Administrator stated, the concerns from the Resident Counsel Meetings were to be addressed as a grievance. Further interview revealed, the facility was doing call light audits before she started at the facility, and they were done at varying times by staff; however, she stated she was unsure if the audits were being conducted on the night shift. She stated she did not think the QA effort to improve the timeliness of answering call bells was effective, and had not corrected the problem.</p> <p>2. Review of the facility's neglect investigation report revealed resident "care questionnaire" interviews performed with interviewable residents revealed nine (9) interviewable residents expressed concern regarding the care received on night shift. These concerns included: call lights not being answered at night; not receiving care as requested during the night or not having care provided during the night; not receiving assistance to get out of bed, go to the bathroom or be changed during the night; and, not receiving pain medication as requested or ordered, or not</p>	F 166			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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F 166	<p>Continued From page 12</p> <p>receiving medications as requested or ordered. The residents included, Resident #8, Resident #16, Resident #17, Resident #24, Resident #26, Resident #32, Resident #33, Resident #35 and Resident #36. However, review of the facility's investigation report revealed no documented evidence the interviewable residents' concerns were investigated and resolved.</p> <p>Interview, on 07/25/14 at 11:20 AM, with Resident #8 revealed although he/she was continent, he/she required assist of one (1) staff to go to the bathroom. Per interview, Resident #8 stated at during the night shift there were "not enough staff and there were "issues" due to staffing. Resident #8 indicated he/she did not recall anyone following up with him/her regarding concerns made on 07/03/14. Review of the Quarterly MDS Assessment, dated 03/30/14, revealed the facility assessed Resident #8 to have a BIMS score of fifteen (15) which indicated no cognitive impairment.</p> <p>Interview, on 07/24/14 at 1:30 PM, with Resident #16 revealed he/she "usually" went to the bathroom on his/her own; however, required assistance to get out of bed. According to Resident #16, he/she had told a nurse about having to wait forty-five (45) minutes for the call light to be answered, but couldn't recall the nurse's name. Resident #16 revealed he/she recalled the facility's Chaplain asking him/her questions about the care before; however, did not recall anyone following up on his/her concerns expressed. Review of the Significant Change MDS Assessment, dated 05/05/14, revealed the facility assessed Resident #16 to have a BIMS score of fifteen (15) which indicated no cognitive impairment.</p>	F 166		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 166	<p>Continued From page 13</p> <p>Additional interview, on 07/24/14 at 1:49 PM, with Resident #17 revealed someone had interviewed him/her regarding concerns he/she had with care on 07/03/14; however, the resident stated no one had followed up with him/her on the concerns expressed. Per interview, Resident #17 stated he/she had still had to wait on his/her call light to be answered for as long as thirty (30) minutes "at times". According to Resident #17, he/she felt the nurses should be on top of call lights and know how long they had been on.</p> <p>Further interview, on 07/25/14 at 9:30 AM, with Resident #24 revealed on 07/03/14, he/she told the SSD of his/her concern about not getting his/her pain medication on 06/27/14 after requesting it three (3) times; however, as of 07/25/14, there had been no follow-up with the resident regarding the concern.</p> <p>Interview with Resident #32, on 07/22/14 at 5:00 PM, on 07/25/14 at 3:30 PM and on 07/31/14 at 6:25 PM, revealed he/she had talked to "the people over the building" previously, but he/she still had to wait for the call light to be answered on day shift and night shift, and he/she still "wet" on himself/herself. The resident stated nothing had been done, and he/she felt staff did not respond to his/her call light in a timely manner. Review of the Quarterly MDS Assessment, dated 04/13/14, revealed the facility assessed Resident #32 to have a BIMS score of fourteen (14) which indicated no cognitive impairment.</p> <p>Additional, interview with Resident #33 on 07/29/14 at 6:30 PM, revealed staff had talked to him/her regarding concerns with night shift; however, no one had followed up with him/her on</p>	F 166		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 166	<p>Continued From page 14 his/her concerns.</p> <p>Interview with Resident #35 was not conducted as the resident had been discharged and was in the hospital. However, review of Resident #35's "care questionnaire" completed by the SSD on 07/03/14, during the facility's investigation, revealed the resident expressed concern regarding not receiving his/her pain medication and other medication the night before. Review of the 07/09/14 MDS Assessment, revealed the facility assessed Resident #35 to have a BIMS score of fifteen (15) which indicated the resident was cognitively intact.</p> <p>Further interview, on 07/24/14 at 2:10 PM, with Resident #36 revealed the resident recalled the "care questionnaire" interview performed on 07/03/14; however, expressed he/she did not recall staff had followed-up in regards to his/her concerns related to call lights and staffing.</p> <p>Interview with the SSD on 07/23/14 at 5:49 PM, revealed when she received grievances or concerns, these were given to the Department Head, and if it had anything to do with nursing it was given to the DON, as the facility used a "team approach". She stated on 07/03/14 she, the Activities Director, Chaplain, and Supply Coordinator had performed interviews with interviewable residents that day. According to the SSD, they had identified resident concerns with "call bells", and she had ensured "call bell audits" were being done on the day and evening shift, then after 07/03/14, she had assured the "call bell audits" were being conducted on all shifts to include the 11:00 PM to 7:00 AM shift. She stated she looked over the "call bell audits" and noted whether there were any complaints.</p>	F 166			

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

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F 166	Continued From page 15 Additional interview on 07/25/14 at 7:20 PM, with the SSD revealed the "call bell audits" were initiated "a few months ago", and the audits were part of the facility's Quality Assurance (QA) process. The SSD stated as the audits were part of the QA she should have been ensuring they were completed on all shifts when they were first initiated. She revealed she had not investigated the other interviewable residents' concerns from the interviews conducted on 07/03/14, until the survey was re-opened on 07/22/14, and the State Survey Agency began interviewing about the concerns. The SSD stated she had not addressed the concerns as grievances and written the concerns up on grievance forms. She indicated she was not sure why she hadn't addressed the residents concerns at the time of the investigation. The SSD stated she "assumed" the former Administrator talked to the DON about the complaints received from other interviewable residents after the interviews were conducted on 07/03/14. In addition, she indicated as she had not addressed the residents' concerns as grievances, she had not documented anything in their records. However, review of the facility's "Investigating a Resident Grievance or Complaint" policy revealed the Administrator would assign the responsibility of investigating grievances and complaints to the SSD or designee, and the SSD or designee would begin an investigation into the allegations. The Policy noted the SSD or designee would include in the investigation: the date and time of the incident reported; the "nature" of the grievance or complaint; the name of any witnesses and their account of the incident; the resident's account of the incident;	F 166			

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

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F 166	<p>Continued From page 16</p> <p>follow-up/recommendation for corrective action; a resolution; and date of the resolution. Further review revealed the grievance or complaint and the corrective action taken were to be documented in the Social Service Progress Notes in the resident's medical record, on the Grievance Complaint Form and noted on the grievance/complaint log. The completed Grievance/Complaint Form was to be maintained on file in the Administrator's office or SSD's office.</p> <p>Interview on 07/25/14 at 7:20 PM, with the HR Director revealed she and the SSD "took direction" from the former Administrator who had not directed them to "follow-up on those concerns" received on 07/03/14. The HR Director stated the former Administrator had not told her or the SSD if she had followed-up on the residents' concerns either. She stated there had been "miscommunication" between the three (3) of them, the former Administrator, herself and the SSD.</p> <p>Further interview with the former Administrator on 07/03/14 at 7:25 PM, and 07/31/14 at 10:14 PM revealed if there was a grievance, a Grievance Form was to be completed and the form would be brought to the morning meeting and discussed and then forwarded to the appropriate department head to investigate. She further stated there was an area on the Grievance Form for findings and conclusions and the corrective action was to be addressed with the person who had the grievance or concern. However, there was no documented evidence this process had been followed. She stated she had not read the resident interviews, as it was verbally reported to her there had been no other resident complaints. The former Administrator stated she had not read the</p>	F 166			

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

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F 166	Continued From page 17 investigation report, and the SSD and Activities Director had conducted resident interviews and "verbally reported back" to her. Further interview with the former Administrator revealed if residents had verbalized concerns during the interviews conducted as part of the investigation, the concerns should have been followed-up on by staff.	F 166			
F 224 SS=K	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on	F 224	F224 Immediate Corrective Action for Residents Found To Be Affected ♦ On July 23 to July 25, 2014 residents #5, 26, 27, 28, and 29 had investigations opened related to allegations of neglect and initial reports were completed as well as 5 day follow-up reports to all appropriate state agencies. SSD met with each of the residents to assess for any issues or complaints.		

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F 224	<p>Continued From page 18</p> <p>07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K".</p> <p>Based on interview, record review, and review of the facility's policy, during the 08/01/14 survey, it was determined the facility failed to ensure residents were free from neglect for five (5) of thirty-seven (37) sampled residents (Residents #5, #26, #27, #28, #29). The facility failed to have an effective system in place to ensure the necessary care and services related to Incontinence care were provided to residents when needed and upon the residents' request.</p> <p>On 07/03/14, Resident #26 rang the call bell for incontinence care assistance at approximately 5:30 AM; however was not assisted until approximately 7:45 AM, (two hours and fifteen minutes later). Interview with the day shift State Registered Nursing Assistant (SRNA), who assisted Resident #26 at 7:45 AM, revealed the resident was soaked with urine and covered in bowel movement. Staff interviews further revealed other residents were also left soaked in urine or soiled with bowel movement the morning of 07/03/14, after day shift reported to work at 7:00 AM. These residents included #5, #27, #28, and #29.</p> <p>After becoming aware of this information on 07/03/14, the facility initiated an investigation and identified a conflict between the two (2) SRNAs normally scheduled on the South Unit who didn't</p>	F 224	<p>Identification of Other Residents with the Potential to be affected</p> <ul style="list-style-type: none"> ◆ 100% of the resident population received head to toe assessments on July 23 to July 28, 2014 by the DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses. ◆ All residents with BIMs of 8 or above were interviewed on July 23 to July 25, 2014 by SSD, HRD/AIT, QoLD, QoLA, MRM, Chaplain, BOM, DOA, ADON, SDC, SCC and ESNS with any concerns voiced taken through the grievance process for follow-up and resolution. ◆ All residents with a BIMS below 8, Responsible Parties, POA or Guardian were interviewed on July 23 to August 04, 2014 by SSD, HRD/AIT, DOA, MRM, Chaplain, BOM, ABOM, ESD, DSM, SCC, ADON, QoLA and QoLD with any concerns taken through the grievance process for follow-up and resolution. Anyone unable to contact were sent certified letters on July 29, 2014. ◆ Staff was interviewed on July 23 to August 10, 2014 for any abuse, neglect or any misappropriation or concerns by the DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, SCC, BOM, DOA, RSM, QoLD, WCN, WNS, Chaplain and SSD. ◆ Initial reports were completed as well as 5 day follow-up for any concerns identified. Thorough investigations were completed and forwarded on to the state agencies as necessary. 		

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

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F 224	<p>Continued From page 19</p> <p>work together to provide care. However, the facility failed to address the interviewed residents' concerns with night shift and failed to address the conflict between the two (2) SRNAs assigned to the unit on the night shift which impacted resident care and left residents at risk for further neglect. (Refer to F-225 and F-226)</p> <p>The facility's failure to have an effective system to ensure residents were protected from neglect was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 07/25/14, and was determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure necessary care and services are provided in regards to having an effective system in place to ensure incontinence care is provided timely and upon request and residents are protected from neglect.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse, Neglect and Misappropriation", dated April 2013 revealed abuse and neglect of residents was prohibited.</p> <p>Review of the facility's Job Description for the</p>	F 224	<p>Measures taken to assure there will not be a Recurrence</p> <ul style="list-style-type: none"> ◆ Education was completed by the SCC on July 23 to July 30, 2014 related to abuse, neglect and misappropriation to DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM and Administrator. Training included investigations, prevention, identification, protection, and reporting as well as providing care per residents individualized care plans. ◆ 100 % of all stakeholder were educated beginning on July 23, 2014 to July 30, 2014 by DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC related to abuse, neglect, misappropriation, incontinence care, and activity of daily living and the answering of call lights. Re-educated all staff on August 25 to September 12, 2014. ◆ Education of abuse, neglect, misappropriation policy will be included in the orientation packet for newly hired employees beginning September 12, 2014. ◆ Post tests were completed for all stakeholders to assure learning and understanding of policy and procedures. 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	<p>Continued From page 20</p> <p>position of SRNA, updated December 2011, revealed licensed nursing personnel were to provide supervision of SRNAs when they performed direct resident care duties. Review of the Job Description revealed SRNA's essential duties and responsibilities included the provision of personal care required by residents daily and as needed.</p> <p>1. Review of Resident #26's medical record revealed the facility admitted the resident on 07/23/12, with diagnoses which included Depressive Disorder, Difficulty Walking, Muscle Weakness, Muscle Disuse Atrophy and Abnormality of Gait. Review of Resident #26's Annual Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed Resident #26 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #26 as requiring: extensive physical assistance of two (2) staff with his/her Activities of Daily Living (ADLs), with bed mobility, transfers and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder and as being at risk for developing pressure ulcers. Review of the Brand Scale for Pressure Sore Risk, dated 06/23/14 revealed the resident was assessed as having a moderate risk for pressure development. Review of Resident #26's Comprehensive Care Plan, dated 06/16/14, revealed the resident was care planned for ADL assistance and for the potential for altered skin integrity.</p> <p>Interview, on 07/03/14 at 2:26 PM, with Resident #26 revealed on 07/03/14, during the night shift</p>	F 224	<ul style="list-style-type: none"> ◆ Beginning August 02, 2014, Ten staff inservice questionnaires are being administered daily DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC to ensure continued understanding of abuse and neglect policy and procedure. Results of the questionnaires and tests are to be reviewed by the Administrator, HRD/AIT, SSD or DON. <i>Any Stakeholder unable to satisfy this requirement will be re-educated until satisfactory completion or removed from the schedule if unable to demonstrate understanding upon re-education. This will continue until instructed otherwise by the QA Committee.</i> ◆ Beginning August 02, 2014, five resident skin assessments per day shall be completed by a licensed nurse for residents with BIMS of less than 8. Results will be reviewed by the DON, ADON, SDC, MDSN or WCN daily. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	<p>Continued From page 21</p> <p>he/she had "pooped" on himself/herself. Resident #26 stated he/she had requested assistance from SRNA #19, who had been assigned to his/her care during the night shift, and SRNA #19 had not assisted with changing the resident after the request. Resident #26 started crying during the interview and stated he/she felt that staff "did not want to change" him/her and felt he/she "wasn't supposed to be clean". Per interview, Resident #26 stated he/she had to wait until day shift came in to get incontinence assistance and get cleaned. Further interview revealed at times he/she had waited for over an hour for staff to answer his/her call light. Resident #26 reported he/she had problems with getting staff to answer his/her call light on the night shift, 11:00 PM to 7:00 AM, and the day shift, 7:00 AM to 11:00 PM.</p> <p>Interview, on 07/03/14 at 7:00 PM, with Registered Nurse (RN) #6, who had worked the night shift from 07/02/14 at 11:00 PM to 07/03/14 at 7:00 AM, revealed at "about 5:30 AM", Resident #26 had requested staff's assistance to get cleaned and changed. Per interview, RN #6 stated she informed SRNA #19 to change Resident #26 as the resident was on intravenous (IV) fluids at seventy-five (75) cc's (cubic centimeters) per hour and this caused the resident to urinate "a lot". RN #6 stated SRNA #19 told her she was getting the residents up, dressed and ready for breakfast and she needed assistance to change Resident #26. According to RN #6, there was a personal conflict between SRNA #19 and SRNA #21, who were the SRNAs regularly scheduled on the unit. According to RN #6, she had assisted SRNA #19 with resident care at approximately 1:30 AM and 3:00 AM. However, RN #6 was passing medication when</p>	F 224	<ul style="list-style-type: none"> ◆ Beginning August 02, 2014, five residents with BIMS greater than 8 will be interviewed daily by DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC and reviewed by the Administrator, HRD/AIT, SSD, or DON. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> ◆ Beginning August 02, 2014, five call light observations will be completed on each shift by the DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> 		

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F 224	<p>Continued From page 22</p> <p>Resident #26 requested assistance at approximately 5:30 AM and had not assisted SRNA #19 to change the resident. Continued interview revealed the personal conflict between SRNA #19 and SRNA #21 had negatively impacted resident care that night. RN #6 stated, as she was SRNA #19's supervisor, she should have informed SRNA #19 not to get residents out of bed as that was not as important as providing resident care as requested and/or needed. She stated even though she knew Resident #26 had requested assistance, she did not ensure it was provided; however, should have followed up to ensure the resident's needs were met. Further interview with RN #6 revealed it would be "terrible" to be wet or soiled and not be changed. She indicated the facility provided training on neglect as a form of abuse, and by not providing the care Resident #26 requested that morning it was neglect. RN #6 stated she had not reported this information to Administration; however, indicated she should have reported the incident.</p> <p>Interview, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, with SRNA #19 revealed early in the morning of 07/03/14, during her last rounds, Resident #26, who was a two (2) person assist, rang the call light and requested incontinence assistance. Continued interview with SRNA #19, revealed she informed Resident #26 as soon as she could get someone to help her she would change him/her. However, she stated she could not get anyone to help her change Resident #26. SRNA #19 stated she asked RN #6 to help her, but she couldn't as she was passing medications. She also asked SRNA #21; however, SRNA #21 "ignored" her. According to SRNA #19, when SRNA #9 and SRNA #6 came to work on the day shift,</p>	F 224	<ul style="list-style-type: none"> ◆ Beginning August 02, 2014, incontinency care observations will be completed for five residents daily licensed nurse and results will be reviewed by the Administrator, DON, ADON, ESNS, WNS or WCN. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> ◆ Beginning August-02 September 22, 2014, the Administrator, SSD or DON will review <i>weekly</i>, all grievances and allegations of abuse, neglect and misappropriation to assure all steps of the abuse, neglect policy and procedure were completed. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> 		

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3578 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 224	<p>Continued From page 23</p> <p>somewhere around 6:45 AM to 7:00 AM, she told them Resident #26 needed to be changed. SRNA #19 stated she took out her trash after telling the day shift SRNAs and went home without returning to Resident #26's room.</p> <p>Interview with SRNA #9, on 07/03/14 at 2:44 PM and on 07/23/14 at 1:52 PM, revealed upon reporting to work at 7:00 AM that morning she had discovered Resident #26 had soiled himself/herself and needed to be cleaned and changed. According to SRNA #9, she had asked SRNA #19, who had been assigned to the residents on night shift, to assist with cleaning and changing the resident. She stated however, SRNA #19 did not assist and walked away. She stated SRNA #20, who had come in early that morning to escort Resident #26 to an appointment, had cleaned and changed the resident upon arrival.</p> <p>Interview, on 07/03/14 at 2:51 PM and on 07/23/14 at 2:26 PM, with SRNA #20 revealed she had reported to work early the morning of 07/03/14 to escort Resident #26 to his/her doctor's appointment. She stated upon her arrival, Resident #26 had bowel movement on his/her clothing and on the pad of the reclining chair the resident was sitting on. Per interview, she had to work for over an hour to assist the resident in getting cleaned. According to SRNA #20, Resident #26 usually requested assistance when he/she needed it, and this was not normal for the resident. SRNA #20 stated Resident #26 "normally" knows when he/she has to have a bowel movement and goes to the bathroom in the wheelchair with two (2) person assist to stand and transfer. She stated Resident #26 told her the "aide" assigned to his/her care had not</p>	F 224	<p>♦ Beginning September 12, 2014 Residents and families attending care plan conferences shall be asked by the SSD, MDSN, QoLD or Licensed Nurse if there have been any concerns and if grievance process has been initiated and followed. If resident or responsible party does not attend the care plan conference the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain, shall attempt to contact via phone x3 for response. <i>Any identified concerns will be investigated by the SCC, Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. Administrator, HRD/AIT, DON, SCC, ADON or SDC will be responsible for re-education and/or disciplinary action up to and including termination shall occur for any failure to follow the grievance process. This will continue until directed otherwise by the QA Committee.</i></p> <p>♦ Investigation relative to SRNA conflict was initiated on July 22, 2014 by HRD/AIT, SCC, DON or ADON interviewing stakeholders working July 2-3, 2014 to identify the conflict that had been reported to OIG. Investigation was completed on July 25, 2014 with SRNA #19 being terminated as a result of the investigation.</p>		

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F 224	<p>Continued From page 24</p> <p>checked on him/her all night on 07/02/14 at 11:00 PM to 07/03/14 at 7:00 AM. Additional interview, with SRNA #20 revealed she reported the condition she had found Resident #26 in on 07/03/14 to LPN #8, and had asked her to come look at the resident; however, LPN #8 could not come "right then".</p> <p>Interview, on 07/03/14 at 5:53 PM, with Licensed Practical Nurse (LPN) #8 revealed SRNA #20 also told her Resident #26 was left wet. LPN #8 revealed when she went to Resident #26's room and spoke to him/her, the resident told her staff had not been in his/her room "all night".</p> <p>Interview, on 07/23/14 at 5:27 PM, with SRNA #16 revealed she had sat with Resident #26 early in the morning on 07/03/14. She stated Resident #26 needed to be changed and she was on "light duty" and could not change the resident. SRNA #16 stated she told SRNA #19 Resident #26 needed to be changed, and SRNA #19 informed her she would change Resident #26 when she "got some help".</p> <p>Interview, on 07/23/14 at 3:49 PM, with RN #4/ADON revealed she had become aware of "a problem with night shift" late in the day on 07/03/14. RN #4/ADON stated she had overheard SRNA #9 talking to someone else about Resident #26 being left wet that morning. She stated she could not recall who SRNA #9 was telling, and stated SRNA #9 did not tell her "directly" about Resident #26. RN #4/ADON stated she did not talk to SRNA #9 about what she had overheard her saying; however, indicated she should have. According to RN #4/ADON, she talked to SRNA #16, as she knew she had been sitting with Resident #26 the morning of</p>	F 224	<p>◆ <i>Conflict Management training was initiated by the HRD/AIT, SCC, DON, ADON, or SDC on 08/29 and was on-going until 09/12. Topics of discussion were: Conflict management- how to handle it, who to communicate it to if you need help resolving; The Hotline policy and procedure; Attendance policy; Staffing Protocols were also reviewed with the nursing staff only. All those not completed by 09/12 were mailed certified letters that training must be completed prior to working again. Starting the week of 9/12 for 4 weeks, HRD/AIT, SCC, DON, ADON, or SDC have completed stakeholder interviews at random with the nursing staff to address/assist with any stakeholder conflict/teambuilding as necessary.</i></p> <p>Monitoring Changes to Assure Continuing Compliance</p> <p>◆ Results of the staff, resident and family interviews, skin assessments, call light observations, and incontinence care observations will be reported weekly x4 to the QA committee by the ADON, MDSN, SDC, WCN, SSD, DON, Administrator or HRD/AIT to determine further need for continued education, revision of plan and process improvements. Any allegations of abuse, neglect and misappropriation will be handled immediately and then reviewed at the weekly meeting beginning August 06, 2014.</p>	
			Date of Completion:	09-27-14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 224	<p>Continued From page 25</p> <p>07/03/14. She stated SRNA #16 told her SRNA #19 told Resident #26 he/she would have to wait for day shift to come in to change him/her.</p> <p>Interview, on 07/03/14 at 6:45 PM, with RN #5/Evening Shift Supervisor revealed at approximately 4:08 PM that day she had spoken with Resident #26 who told her SRNA #19 had left him/her "wet and with crap" on him/her. RN #5/Evening Shift Supervisor stated she went to the Director of Nursing (DON) and Social Services Director (SSD) and reported to the DON and SSD what Resident #26 had told her. Per interview, RN #5/Evening Shift Supervisor revealed staff should not "knowingly" leave residents wet and soiled as that would be a form of neglect.</p> <p>Further interview with SRNA #9, 07/03/14 at 2:44 PM, revealed several other residents were found "soaked" with urine or soiled on 07/03/14 which included Residents #5, Resident #27, Resident #28, and Resident #29.</p> <p>2. Review of Resident #5's medical record revealed the facility re-admitted the resident on 04/10/14, with diagnoses which included Sepsis, Arthritis, Osteoporosis and Muscle Weakness. Review of Resident #5's Quarterly MDS Assessment, dated 05/15/14, revealed the facility assessed the resident as having severe cognitive impairment, and to require extensive physical assistance of two (2) staff with his/her ADLs including bed mobility, transfers and toileting. Further review of the MDS Assessment revealed the facility assessed Resident #5 to always be incontinent of bowel and bladder. Continued review of the MDS revealed the resident was assessed as being at risk for pressure ulcers and</p>	F 224		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 224	<p>Continued From page 26</p> <p>as having a pressure ulcer. Review of the Brand Scale for Pressure Sore Risk, dated 05/15/14 revealed the resident was assessed as having a moderate risk for pressure. Continued record review revealed Resident #5 had a history of a Stage II pressure ulcer to the coccyx which was resolved on 05/26/14. Review of Resident #5's Comprehensive Care Plan, dated 06/03/14, revealed the resident was care planned as requiring extensive assistance with bed mobility and for the potential for complications related to his/her incontinence of bowel and bladder. Continued review of the Comprehensive Care Plan revealed the resident was at risk for developing skin breakdown. Review of the interventions revealed treatments were provided from 04/11/14 through 05/26/14 at which time the Stage II was noted as being healed.</p> <p>Additional interview, on 07/23/14 at 12:05 PM, with LPN #8 revealed SRNA #9 had come to her the morning of 07/03/14 and reported Resident #5 being soiled. She stated she had told SRNA #9 to clean and change the resident immediately. Per interview, LPN #8 stated when she went to Resident #5's room, the resident was "pretty wet" but she could not recall if the bed was wet.</p> <p>3. Review of Resident #27's medical record revealed the facility admitted the resident on 06/14/13, with diagnoses which included Fracture of the Femur, Difficulty Walking, Muscle Weakness, Anxiety and Senile Dementia. Review of Resident #27's Quarterly MDS Assessment, dated 05/21/14, revealed the facility assessed the resident to have severe cognitive impairment, and to require extensive physical assistance of two (2) staff with his/her ADLs including transfers, bed mobility and toileting.</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 224	<p>Continued From page 27</p> <p>Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder and as being at risk for developing pressure sores. Review of the Braden Scale for Pressure Sore Risk, dated 05/21/14 revealed the facility assessed the resident as being at a high risk for pressure sore development. Review of Resident #27's Comprehensive Care Plan, dated 05/28/14, revealed the resident was care planned for ADLs and for the potential for complications related to his/her incontinence of bowel and bladder. Continued review of the Comprehensive Care Plan revealed Resident #27 was care planned for the risk of developing skin breakdown and as needing extensive/total assistance with bed mobility.</p> <p>4. Review of Resident #28's medical record revealed the facility admitted the resident on 03/06/13, with diagnoses which included Muscle Weakness, Difficulty in Walking, Failure to Thrive, Chronic Kidney Disease and Renal Failure. Review of Resident #28's Quarterly MDS Assessment, dated 03/26/14, revealed the facility assessed the resident to have severe cognitive impairment, and to require extensive physical assistance of two (2) staff for most ADLs including transfers and bed mobility and extensive assist of one (1) staff for toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be frequently incontinent of bowel and bladder and as having no pressure but as being at risk for skin break down. Review of Resident #28's Comprehensive Care Plan, dated 06/03/14, revealed the resident was care planned for ADLs and for the potential for complications related to his/her incontinence of bowel and bladder and for the potential for</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 224	<p>Continued From page 28</p> <p>altered skin integrity. Review of the Pressure Ulcer Braden Scale, dated 06/26/14 revealed the facility assessed the resident to be at moderate risk for skin breakdown.</p> <p>5. Review of Resident #29's medical record revealed the facility admitted the resident on 09/28/12, with diagnoses which included Abnormality of Gait, Muscle Weakness, history of Urinary Tract Infections (UTIs) and Alzheimer's Disease. Review of Resident #29's Quarterly MDS Assessment, dated 07/07/14, revealed the facility assessed the resident to have severe cognitive impairment, and to require extensive physical assistance of two (2) staff with ADLs including transfers, bed mobility and toileting. Further review of the MDS Assessment revealed the facility assessed the resident to be always incontinent of bowel and bladder and as being at risk for the development of pressure ulcers. Review of the Braden Scale for Predicting Pressure Sore Risk, dated 07/07/14 revealed the facility assessed the resident as having a mild risk for the development of pressure sores. Review of Resident #29's Comprehensive Care Plan, dated 06/01/14, revealed the resident was care planned for ADLs and for the potential for complications related to his/her incontinence of bowel and bladder. Continued review of the Comprehensive Care Plan revealed the resident was care planned for the potential for altered skin integrity related to decreased physical and cognitive function.</p> <p>Additional interview, on 07/03/14 at 5:53 PM, with LPN #8 revealed on the morning of 07/03/14, after reporting to work at 7:00 AM, SRNA #32 came and got her to look at the condition Resident #29 had been left in by night shift. LPN</p>	F 224		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 224	<p>Continued From page 29</p> <p>#8 stated Resident #29 was "beyond soaked" that morning, and indicated it appeared as though the resident had not been changed at all during the night.</p> <p>Interview, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, with SRNA #19 revealed she had not been able to perform incontinence care on Resident #29 during her last rounds on 07/03/14 as he/she was also a two (2) person assist.</p> <p>Continued interview with SRNA #19, on 07/03/14 at 4:45 PM and on 07/23/14 at 9:08 AM, revealed there was a conflict between her and SRNA #21 who wouldn't talk to her, and they did not work well together because of this. Per interview at times she had worked the entire South Unit by herself due to SRNA #21 not wanting to work with her. SRNA #19 stated she had informed the nurses and they were aware of the conflict; however, nothing had been done. Further interview with SRNA #19 revealed neglect was a form of abuse, and it was neglect "for residents not to be changed when needed". However, SRNA #19 denied leaving residents wet or soiled, not changed, or unattended.</p> <p>Interview, on 07/23/14 at 4:36 PM, with SRNA #21 revealed she worked on the South Unit. She stated SRNA #19 had not requested her assistance early in the morning of 07/03/14. SRNA #21 stated she and SRNA #19 did not have a "very good" relationship. She stated SRNA #19 did not want to work with her, thought she did not like her, and would not ask her for assistance. SRNA #21 reported SRNA #19 told "everyone" she refused to help her; however, indicated she assists if SRNA #19 asked her.</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 224	<p>Continued From page 30</p> <p>Continued interview with SRNA #21 revealed SRNA #19 would ask the nurses or SRNAs on the North Unit to help her. SRNA #21 stated she just liked to get her work done on her hall and did not socialize "a lot". SRNA #21 indicated if residents were not being changed, ringing their call light for assistance or being left wet it would be abuse in the form of neglect. She stated "no one wants to be left wet". Per interview, SRNA #21 stated if SRNA #19 asked her for assistance she would help her.</p> <p>Interview, on 07/29/14 at 3:20 PM, with SRNA #31 revealed staff was aware of the conflict between SRNA #19 and SRNA #21 which had been going on for "months". SRNA #31 stated SRNA #19 and SRNA #21 complained about each other to other people. Per interview, SRNA #31 stated he/she had not told nurses or other supervisory staff about it.</p> <p>Interview, on 07/30/14 at 2:55 PM, with SRNA #18 and SRNA #20 revealed they were both aware of the conflict between SRNA #19 and SRNA #21. SRNA #20 stated when SRNA #19 and SRNA #21 worked at night they did not work together and did not answer call lights for each other. Both SRNAs stated "everybody" knew about the conflict between the two (2) SRNAs and indicated the conflict impacted resident care. SRNA #20 stated there had been times SRNA #19 had left residents "soaking wet" and with bowel movement on them at the end of her shift. According to SRNA #20, there was no need to tell nurses about the conflict because they knew what was going on.</p> <p>Interview, on 07/24/14 at 9:11 PM with SRNA #4 who worked day shift, revealed she had rounded</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 224	<p>Continued From page 31</p> <p>before on residents who SRNA #19 had been assigned to provide care and had found five (5) residents wet, with their "full" bed wet with urine, which required a complete bed linen change. She stated she did not report this to anyone as she was not usually assigned to work the South Unit.</p> <p>Further interview, on 07/03/14 at 5:53 PM, with LPN #8 revealed she had noticed when a certain SRNA, whose name she could not recall, worked it looked as if rounds were not being performed on night shift. Per interview, LPN #8 revealed she did not tell her supervisor about what Resident #26 had told her, or of the condition other residents had been left in, as she had observed SRNA #9 going to the Staff Development Coordinator (SDC) to tell her about the condition residents had been left in that morning.</p> <p>Further interview with SRNA #9, 07/03/14 at 2:44 PM, revealed she was so upset over the condition the residents had been left in, on 07/03/14 by SRNA #19, she went to the SDC to report the residents being left "soaked" and "soiled". Additional interview with SRNA #9 revealed when she reported the incident of residents being left "soaked" and "soiled" to the SDC on the morning of 07/03/14, the SDC told her to "write it up" and she would take it to the Human Resources (HR) Director. However, SRNA #9 stated she never wrote up the incidents. SRNA #9 stated "almost daily" when she came to work after SRNA #19 had worked the previous shift, she found her residents "wet" and their beds needing to be changed. Per interview, SRNA #9 stated it was "neglect" to leave residents "wet".</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 32</p> <p>Interview, on 07/03/14 at 6:41 PM, with the SDC revealed no staff had reported to her that morning the condition residents had been left in, nor had she spoken to residents. However, interviews with SRNA #9 and LPN #8 revealed SRNA #9 had reported the residents' condition to her. The SDC stated if she had been informed of a reportable situation by staff she would have directed them to tell the Assistant Director of Nursing (ADON) and "follow the chain of command".</p> <p>Interview, on 07/03/14 at 2:51 PM and on 07/23/14 at 2:26 PM, with SRNA #20 revealed when reporting to work on day shift at 7:00 AM, in a week's time she had had to change several residents three (3) times out of the week. Further interview with SRNA #20 revealed she had told Registered Nurse (RN) #4/Assistant Director of Nursing (ADON) of her concern regarding residents' care. She reiterated three (3) to four (4) days out of the week finding residents "wet" when she reported to work at 7:00 AM.</p> <p>Interview, on 07/03/14 at 4:35 PM and on 07/23/14 at 3:49 PM, with the RN #4/ADON revealed she was not aware of the incidents involving Resident #5, Resident #26, Resident #27, Resident #28 and Resident #29 which had taken place the morning of 07/03/14 until later that day. She stated a staff member did tell her residents had not been "touched in awhile"; however, the staff person did not tell her which residents were involved and to what extent. The ADON stated her expectation was for night shift and day shift to do rounds on residents prior to night shift leaving the facility. She indicated staff should not leave residents soiled.</p>	F 224		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 33</p> <p>Interview, on 07/03/14 at 5:20 PM, with the Director of Nursing (DON) revealed she was not made aware of Resident #26 and the other residents having been left wet and soiled by night shift for day shift to change until about an hour before the current interview with the State Survey Agency. The DON stated an investigation had been started regarding the incident after she was notified. She stated the RN Evening Shift Supervisor notified her. Continued interview with the DON revealed residents should not be left wet and soiled by any shift.</p> <p>Interview, on 07/03/14 at 7:25 PM, with the Administrator revealed it was her expectation staff would ensure residents were clean and dry. She stated staff should be completing rounds every two (2) hours as per the facility's policy. The Administrator stated for residents who need it, rounds should be completed more frequently. Continued interview with the Administrator revealed if a resident was fully saturated with urine, then the employee should be removed from duty and a full investigation initiated to determine if there was a neglect related to the resident's care. The Administrator stated she would have wanted to have been notified that morning when the incident involving the residents had occurred. The Administrator indicated any form of abuse or neglect of residents should be reported to Administration immediately and residents being left soiled was a form of neglect.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 that alleged removal of the IJ effective 07/29/14. Review of the AOC revealed the facility implemented the following:</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 34</p> <p>1. The facility opened and investigated the five (5) reported allegations of neglect identified on the 06/30/14 through 07/03/14 Survey for Residents #5, #26, #27, #28, and #29. Initial Reports were completed with the five (5) day follow up reports pending completion of the investigations. The allegations were investigated by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant.</p> <p>2. One hundred percent (100%) of the resident population received head to toe assessments by the DON, the ADON, MDS Coordinator, Wound Care Nurse, SDC, Evening Nurse Supervisor, Corporate Nurse Consultant and Charge Nurses on 07/23/14.</p> <p>3. Residents with a BIMS of eight (8) or above were interviewed by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Supply Coordinator, Quality of Life Director or Chaplain which was completed on 07/25/14 for any abuse, neglect, or misappropriation concerns.</p> <p>4. Families and responsible parties were interviewed for residents with a BIMS below eight (8) which was initiated on 07/25/14 and as of 07/28/14, thirty-seven (37) of fifty-six (56) had been completed, for any abuse, neglect, or misappropriation concerns. The facility would continue to attempt contacting families and responsible parties daily to identify any concerns until remaining Power of Attorney's (POA's) had been reached. Concerns were addressed per</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 35</p> <p>policy and procedure as to reporting requirements and resident protection.</p> <p>5. Staff was interviewed for any abuse, neglect, or misappropriation concerns by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Quality of Life Director or Chaplain on 07/25/14. Initial reports were made on the allegations relative to those interviews.</p> <p>6. Initial Reports were made on 07/25/14 related to the alleged allegations relative to the interviews with residents, families, responsible parties, and staff. Thorough investigations were initiated on 07/25/14 by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant on those residents identified with appropriate follow up reporting on the allegations received.</p> <p>7. Abuse, neglect and misappropriation audits, assessments, interviews and questionnaires were reviewed by the Special Projects Administrator, DON, Corporate Nurse Consultant or Chief Nurse Executive on 07/27-07/28/14 for any indications of abuse, neglect or misappropriation concerns.</p> <p>8. The Medical Director was notified of the Immediate Jeopardy on 07/25/14 by the DON and Special Projects Administrator. An Emergency Quality Assurance (QA) Meeting was held on 07/26/14 with the Corporate Director of Risk Management, Clinical Nurse Executive, Corporate Nurse Consultant, Medical Director, Special Projects Administrator, DON, HR</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

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F 224	<p>Continued From page 36</p> <p>Director, SSD and SDC related to the Immediate Jeopardy.</p> <p>9. The DON, two (2) ADONs, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions, Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse were re-educated on 07/23/14 and the Administrator was re-educated on 07/28/14, upon his return, by the Corporate Nurse Consultant on the Abuse, Neglect and Misappropriation Policy and Procedure which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans. They could not return to work until the abuse, neglect, misappropriation education was provided and post test administered and a one hundred percent (100%) score was obtained on the post test. If a manager did not score a one hundred percent (100%) on post test, the manager was immediately re-educated and a post test was re-administered.</p> <p>10. The facility's Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse educated stakeholders related to the Abuse, Neglect, and Misappropriation Policy which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care</p>	F 224		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 224	<p>Continued From page 37</p> <p>plans starting on 07/23/14 and continued until 07/28/14. No staff would be allowed to work until this education was provided and the post test administered and a one hundred percent (100%) score obtained. Eighty-seven (87) of ninety-six (96) were completed by 07/28/14.</p> <p>11. Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse provided education to stakeholders which was initiated on 07/26/14 to nursing staff related to incontinence care and Activities of Daily Living (ADL's) care per the Care Plan and answering call lights. Calls and certified letters had been sent notifying staff they must complete training before returning to work relative to incontinence care and Activities of Daily Living (ADL's) Care per resident individualized Care Plan and answering call lights in a timely manner.</p> <p>12. Education regarding the Abuse, Neglect and Misappropriation Policy would be included in the orientation process for newly hired staff. No newly hired person would be able to work until this education was provided and a post test administered and one hundred percent (100%) score obtained provided by staff development.</p> <p>13. Staff assessment of knowledge test regarding abuse, neglect and misappropriation was being administered by the Administrator, DON, ADON's, MDS Coordinator, SDC, Dietary Director, Medical Records Director, Business</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 224	<p>Continued From page 38</p> <p>Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse to five (5) staff members on each shift and different staff members until the immediacy was removed.</p> <p>14. Ten (10) staff questionnaires would be administered daily to ensure continued understanding of the Abuse, Neglect and Misappropriation Policy. Results of the questionnaires, tests, ten (10) resident skin assessments of residents with a BIMS less than eight (8) per day, ten (10) residents with a BIMS greater than eight (8) interviews would be reviewed daily until the immediacy was resolved by the Administrator, DON, Nurse Consultant or Chief Nurse Executive. Any concerns revealed on the above to include injuries of unknown source would be reported immediately to the Abuse Coordinator, Administrator, DON, Corporate Nurse Coordinator, Regional Vice President of Operations, Special Projects Administrator, or Chief Nurse Executive.</p> <p>15. Results of the staff questionnaires, resident interviews and skin assessments would be reviewed daily by the Administrator, DON, Nurse Consultant or Chief Nurse Executive with results reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of plan. Based on the evaluation the QA Committee would decide at what frequency the staff questionnaire would need to continue. Concerns identified would be corrected immediately and reported to the Administrator or DON to ensure an</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 224	Continued From page 39 Investigation of suspected abuse, neglect or misappropriation was investigated/completed and reporting guidelines were met along with any reporting of violation of resident rights. 16. Administrator, DON, ADONs, MDS Coordinator, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Director, Plant Operations Director, Quality of Life Director, Wound Care Nurse, Corporate Nurse Consultant, Regional Vice President or Clinical Nurse Executive would conduct call light audits through direct observation and monitoring tool daily twenty-four (24) hours a day seven (7) days a week on each shift to monitor compliance until the immediacy was removed. Then five (5) call lights daily on each shift (fifteen (15) total) ongoing and reported to QA Committee weekly during immediacy and monthly after immediacy was removed. Charge Nurses would provide direct observation of call light responsiveness and ensure all residents were getting needs met for plan of care each shift. Incontinence care observation would be completed for ten (10) residents daily until the immediacy was removed then ongoing for five (5) residents daily with results being reported to the QA Committee weekly during immediacy and monthly after the immediacy was removed. 17. Human Resources (HR) Director performed an audit of staff files for any abuse, neglect or misappropriation concerns 7/26/14 through 7/27/14 and the items reviewed included coaching, counseling forms, suspension forms, termination forms, abuse registry checks,	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 224	<p>Continued From page 40</p> <p>background checks and licensure to 07/03/14. Results of the audit was given to the Administrator, DON or Corporate Nurse Consultant on 07/27/14, to review for any abuse, neglect or misappropriation concerns that needed reported. None were identified.</p> <p>18. Information on "Caring for the Caregiver" which addresses the signs of stress and burn out, showing the caregiver ways to cope and reduce stress and useful ways that friends could offer help to the caregiver were posted by the time clock on 07/27/14 by the Special Projects Administrator.</p> <p>19. A nurse from the regional team or corporate office had been onsite since 07/21/14 and would remain in the facility daily until the Immediate Jeopardy was lifted. The nurses from the regional team home office were assisting with investigations, observing staff treatment of residents, performing chart audits and providing oversight and consultation. The Chief Nurse Executive would be in daily contact with the Corporate Nurse Consultant and would review allegations.</p> <p>20. Grievances and Resident Questionnaires since 07/23/14 were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director or Regional Nurse Consultants 07/27/14 through 07/28/14 to determine if any items documented were a reportable event. All issues identified were reported and investigations initiated per the facility's policy and procedure. The Administrator, SSD, or the DON would review daily, the grievances and Incident/Accident Reports, until immediacy was lifted, starting 07/27/14 to</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 224	<p>Continued From page 41</p> <p>determine if there were reportable allegations which had been identified, then daily Monday through Friday during the Morning Stand-Up Meeting. SSD or the DON would report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator would review any allegations of abuse, neglect or misappropriation for reporting to the Office of Inspector General, Adult Protective Services and Ombudsman and appropriate authorities as required by state law.</p> <p>21. The Administrator, DON, SSD would review and discuss abuse, neglect and misappropriation allegations daily to ensure the resident was protected, the perpetrator was removed from resident care area, reports to the State Survey Agency, APS and Ombudsman were filed timely, and a thorough investigation was completed. The Abuse Coordinator (SSD) would maintain an abuse, neglect and misappropriation investigation log starting on 07/27/14 that would include documentation of the following: validate protection of residents; perpetrator was removed from resident care area; reports to the State Survey Agency and Adult Protective Services (APS) were filed timely; and a thorough investigation was completed. The Abuse Coordinator and one of the following: Administrator, DON, Chief Nurse Executive or Regional Nurse Consultant would review the abuse, neglect and misappropriation log daily until removal of the Immediate Jeopardy, beginning on 07/27/14, to validate protection of the resident, that the perpetrator was removed from the resident care area, that reports to the State Survey Agency and APS and appropriate authorities required by state law, were filed timely, and a thorough investigation had been</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 42 completed.</p> <p>22. In the event of any new reports of alleged abuse, neglect, or misappropriation of property, after the Immediate Jeopardy was removed, the Signature Care Consultant or Chief Nursing Executive would validate the resident was protected, report was filed timely, the perpetrator was removed from resident care area and a thorough investigation was completed.</p> <p>23. Beginning on 07/27/14, the care plan conferences for each resident would include any abuse, neglect or misappropriation concerns which the residents or families had. Resident safety would be validated and then the allegation would be reported to the Charge Nurse. The Abuse, Neglect and Misappropriation Policy would then be followed.</p> <p>24. Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, Chief Nursing Officer, Signature Care Consultant, member of the regional staff team or Chief Operating Officer daily until removal of the immediacy beginning 07/21/14, then weekly for four (4) weeks, then monthly.</p> <p>25. A Quality Assurance Meeting would be held weekly for four (4) weeks beginning 07/26/14, 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.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p>	F 224		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	Continued From page 43 1. Review of the facilities investigations revealed the five (5) reported allegations involving Resident's #5, #27, #28, and #29 have been completed with a five (5) day follow up. A re-investigation was done related to allegations for Resident #26. Interview, on 07/31/14 at 7:08 PM, with the Corporate Nurse Consultant revealed the facility had investigated the allegations regarding Resident's #5, #26, #27, #28, and #29 and found them all to be substantiated. 2. Review of copies of resident head to toe assessments revealed all residents were assessed and the assessments were performed on 07/23/14 on North and South Hall, with a recorded census on 07/23/14 of fifty six (56) residents on North Hall and fifty-one (51) residents on South Hall. There was no concerns revealed during review of the skin assessments. Interview, on 07/31/14 at 5:26 PM, with the Wound Care Nurse revealed she was in charge of the skin assessments, and she and other nurses completed skin assessments on one hundred percent (100%) of the residents in the building. 3. Review of Resident Interviews revealed residents with a BIMS of eight (8) and above were interviewed, which included forty-six (46) residents, related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. 4. Review of family interviews for residents with a	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 44</p> <p>BIMS of less than eight (8) revealed thirty-seven (37) of fifty-six (56) of these interviews were completed as of 7/28/14 related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed the interviewable residents were interviewed, as well as, the families of residents with a BIMS score of less than eight (8) and she reviewed the interviews for any concerns.</p> <p>5. Review of the Stakeholder (Staff) Investigative Interviews revealed they were conducted in reference to abuse, neglect and misappropriation concerns 7/23/14 through 7/25/14 for all regular and part-time staff.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all interviewed and asked if they were aware of any abuse, neglect, or misappropriation.</p> <p>6. Review of the allegations relative to the interviews with residents, families, responsible parties, and staff concerns revealed they were</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 45 investigated with initial reports completed.</p> <p>Interview with the Corporate Nurse Consultant on 07/31/14 at 7:08 PM revealed there was several reportable allegations from the interviews which she assisted with conducting, and the facility investigated with follow up actions and reporting.</p> <p>7. Review of the Abuse, Neglect, and Misappropriation audits, assessments, interviews and questionnaires revealed they were reviewed by the DON, Corporate Nurse Consultant, Chief Nurse Executive or Special Projects Administrator on 07/27/14 and 07/28/14.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed they expanded on the abuse questions giving scenarios to the staff to have them choose which type of abuse was occurring in the scenarios. She stated she reviewed the abuse audits, assessments, interviews, and questionnaires.</p> <p>8: Review of the Quality Assurance Signature Sheet and Minutes revealed an Emergency QA meeting was held on Saturday, 07/26/14, with the Medical Director, Special Projects Administrator, Director of Nursing Services, Director of Clinical Risk Management, Staff Development, Certified Nurse Executive, Corporate Nurse Consultant, Human Resources Director, and Social Services Director to discuss current Immediate Jeopardy deficiencies and a Plan of Correction.</p> <p>Interview with the DON on 08/01/14 and the Corporate Nurse Consultant on 07/31/14 at 7:08 PM confirmed the QA Meeting was held on 07/26/14 with the Medical Director. Interview with the HR Director on 07/31/14 at 5:45 PM revealed</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 46</p> <p>during the emergency QA Meeting they discussed the Immediate Jeopardy deficiencies and the reason for the deficiencies as well as discussed the audits, interviews, questionnaires and interviewing that was being done related to the deficiencies.</p> <p>9. Review of the sign in sheets dated 07/23/14 regarding training for the Administrative staff of the facility regarding the Abuse, Neglect and Misappropriation Policy revealed the Certified Nurse Executive educated the DON, ADON's, MDS Coordinator, SDC, Dietary Director, Business Office Manager, Social Services Director, Chaplain, Admissions Director, Medical Records, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse received the training.</p> <p>Review of the sign in sheet on 07/28/14 for training on the Abuse, Neglect and Misappropriation Policy, revealed the Administrator of the facility was educated on skin assessments, interviews, the Abuse, Neglect, and Misappropriation Policy, and the Education session regarding the Plan of Correction.</p> <p>Interview with the ADON/UM of the South Unit on 07/31/14 at 3:30 PM, ADON/UM of the North Unit on 07/31/14 at 4:45 PM, HR Director on 07/31/14 at 5:45 PM, the Dietary Director on 07/31/14 at 6:15 PM, and the DON on 08/01/14 at 10:00 AM, revealed they received training on abuse, neglect and misappropriation and had to take a post test in which they had to score a one hundred percent (100%).</p>	F 224		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 47</p> <p>Review of the post test administered for Department Administrative Managers revealed a score of one hundred percent (100%) related to abuse, neglect, and misappropriation education.</p> <p>Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant, revealed the Department Administrative Managers scored a one hundred percent (100%) on the post test related to abuse, neglect and misappropriation education.</p> <p>10. Review of the inservices revealed education was conducted with stakeholders related to abuse, neglect, and misappropriation 07/23/14 through 07/28/14 in which they had to score a one hundred percent (100%) on the post test or retake the test.</p> <p>Interview with the Staff Development Coordinator (SDC) on 07/31/14 at 5:15 PM, and the SSD on 07/31/14 at 6:30 PM revealed she and other administrative staff educated the stakeholders related to abuse, neglect and misappropriation and completed these inservices.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 224	<p>Continued From page 48</p> <p>educated on the facility's Abuse, Neglect and Misappropriation Policy, which included training, prevention, identification, investigation, protection and reporting.</p> <p>Review of the sign in sheets from 07/23/14 through 07/28/14 revealed inservices were conducted with the facility staff regarding the Abuse and Neglect Policy. Review of the post-test revealed some staff had to be re-educated and staff eventually received a one hundred percent (100%) on the post tests. Documentation provided from the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated related to abuse, neglect, and misappropriation in which they had to score a one hundred percent (100%) on the post test or retake the test.</p> <p>11. Review of the sign in sheets on 7/26/14 and documentation of education provided revealed additional education was conducted with</p>	F 224		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 224	<p>Continued From page 49</p> <p>stakeholders regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner to the facility staff. Review of documentation provided by the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Further review revealed the stakeholders had to score a one hundred percent (100%) on the post test or retake the test. Further review revealed all but four (4) prn (as needed) staff had taken the test and scored a one hundred percent (100)%.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received inservice training regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner.</p> <p>12. Review of the new orientation schedule revealed all new employees will complete education regarding the facility's abuse and neglect and successfully complete post test.</p> <p>Interview with the SDC on 07/31/14 at 5:15 PM confirmed the abuse and neglect education was a</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 224	<p>Continued From page 50 part of the new orientation schedule for new employees.</p> <p>13. Review of the Stakeholder Assessment of Knowledge Tests regarding the Abuse, Neglect and Misappropriation Policy revealed the test was administered to five (5) stakeholders each shift and continued with different stakeholders.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received the Assessment of Knowledge Test regarding abuse, neglect and misappropriation.</p> <p>14. Review of the questionnaires, skin assessments, and interviews revealed ten (10) stakeholder questionnaires, ten (10) skin assessments for residents with a BIMS of less than eight (8), and ten (10) interviews with residents with a BIMS of eight (8) or greater than eight (8) were administered daily related to understanding of the abuse, neglect, and misappropriation policy. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the DON on 08/01/10 at 10:00 AM</p>	F 224		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 51</p> <p>revealed, the facility was still administering ten (10) questionnaires to stakeholders a day, performing ten (10) skin assessments a day for residents with a BIMS of less than eight (8), and conducting ten (10) interviews a day with residents who had a BIMS of eight (8) or greater related to abuse, neglect, and misappropriation.</p> <p>15. Review of the QA Minutes dated 07/26/14 revealed the stakeholder questionnaires, resident skin assessments and resident interviews were to be reviewed daily and results and were to be reported to QA weekly.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed the stakeholder questionnaires, skin assessments and resident interviews were reviewed daily by her and taken to the QA Meeting weekly.</p> <p>16. Review of the call light audits revealed monitoring was being done twenty-four hours (24) a day on each shift. Further review of the call light audits revealed five (5) call lights audits was being done daily on each shift (fifteen (15) total) which was ongoing. Review of the audits for Incontinence care revealed observation of incontinence care was completed for ten (10) residents daily. Review of the call light audits revealed an improvement in call light response time as the auditing continued.</p> <p>Interview on 07/31/14, with LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; and LPN #13 at 6:05 PM verified, as charge nurses they were providing direct observation of call light responsiveness and ensuring the residents were getting needs met as per the care plan.</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 52</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed call light audits were still being done twenty-four (24) hours a day on each shift and observation of incontinence care was still being done for ten (10) residents daily and the results of the audits would be taken to the weekly QA Meeting.</p> <p>17. Review of the audits revealed the Human Resources Director conducted an audit of the personnel charts for any history of abuse, neglect, or misappropriation concerns and no concerns were identified.</p> <p>Interview with the HR Director on 07/31/14 at 5:45 PM revealed she had performed an audit of the personnel files looking for any abuse charge, coaching/counseling/suspension/termination related to abuse, license verification, criminal background checks and abuse registry checks.</p> <p>18. Observation on 07/31/14 at 11:00 AM revealed a sign was posted by the time clock to personnel to address Caring for the Caregiver - signs of stress and burn-out.</p> <p>Interview with SRNA #24, on 07/31/14 at 2:00 PM, revealed she was aware of the sign at the timeclock related to stress and burn out.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed there was a sign posted by the timeclock for personnel related to what to do if feeling stress and burn out.</p> <p>19. Observation revealed a nurse from the corporate office of the facility was present on the facility throughout the survey.</p>	F 224		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	Continued From page 53 Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant revealed a Corporate Nurse had been in the building since 07/21/14 on someone would remain at the facility until the immediacy was removed. 20. Review of the Grievances and Resident Questionnaires since 07/23/14 revealed they were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director and/or Regional Nurse Consultants by 07/28/14. Concerns were addressed per policy and procedure as to reporting requirements and resident protection. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed he had been reviewing daily the grievances, incident reports and resident and staff questionnaires to identify any reportable allegations and the facility was reviewing them daily Monday through Friday in the morning stand up meeting. He stated the DON and SSD were to report any allegations of abuse to him and he was to review the investigations to ensure there was corrective action, appropriate follow up, and reporting. 21. Review of the Allegation Log, revealed the following; validate protection of residents, perpetrator removed from resident care area, reports to the Inspector General and APS were filed timely, and a thorough investigation was completed. Interview with the SSD on 07/31/14 at 6:30 PM revealed she was the Abuse Coordinator and she reviewed allegations of abuse and grievances daily with the Administrator. She stated Accident	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 224	<p>Continued From page 54 and incident reports, allegations of abuse/neglect/misappropriation and grievances were reviewed daily in the clinical meeting Monday through Friday with the DON and other Administrative Staff. She stated there was a new tool used for logging investigations which included the date of submission, resident name, description of allegation, perpetrator, date the five (5) day investigation was to be completed, and the date state agencies were notified of the findings. The SSD stated she was responsible for keeping the log up to date with new reportable allegations.</p> <p>22. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation that in the event of any new reports of alleged abuse, neglect, or misappropriation the Signature Care Consultant or Chief Nursing Executive would be contacted prior to making the final five day investigation to the State Survey Agency to validate the resident was protected, report was filed timely, the perpetrator was removed from the patient area and a thorough investigation was completed.</p> <p>Interview with the Administrator on 08/01/14 at 11:46 AM, revealed in the event of any allegation of abuse, neglect or misappropriation, corporate was to review the investigation prior to sending the five (5) day final report to the State Survey Agency.</p> <p>23. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation stating care plan conferences would include any abuse, neglect or misappropriation concerns that the families or residents may have.</p>	F 224			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3578 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 224	Continued From page 55 Interview with the DON on 08/01/14 at 10:00 AM, revealed all care plan conferences would include questioning residents and families about any concerns related to abuse, neglect or misappropriation. 24. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed Corporate Administrative oversight of the facility was to continue until the immediacy was removed, then would continue weekly for four (4) weeks and then monthly. 25. Interview on 08/01/14 at 11:46 AM with the Administrator confirmed there would be a weekly QA meeting to include Corporate oversight weekly for four (4) weeks, then monthly and the last meeting was 07/26/14. He stated during the meeting they would discuss the audits and recommendations for frequency of continued audits related to the deficiencies cited.	F 224			
F 225 SS=K	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	F 225	F-225 Immediate Corrective Action for Residents Found To Be Affected ♦ On July 23 to July 25, 2014 residents #5, 26, 27, 28, and 29 had investigations opened related to allegations of neglect and initial reports were completed as well as 5 day follow-up reports to all appropriate state agencies. SSD met with each of the residents to assess for any issues or complaints.		

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

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F 225	<p>Continued From page 56 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: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30</p>	F 225	<p>Identification of Other Residents with the Potential to be affected</p> <ul style="list-style-type: none"> ◆ 100% of the resident population received head to toe assessments on July 23 to July 28, 2014 by the DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses. ◆ All residents with BIMs of 8 or above were interviewed on July 23 to July 25, 2014 by SSD, HRD/AIT, QoLD, QoLA, MRM, Chaplain, BOM, DOA, ADON, SDC, SCC and ESNS with any concerns voiced taken through the grievance process for follow-up and resolution. ◆ All residents with a BIMS below 8, Responsible Parties, POA or Guardian were interviewed on July 23 to August 04, 2014 by SSD, HRD/AIT, DOA, MRM, Chaplain, BOM, ABOM, ESD, DSM, SCC, ADON, QoLA and QoLD with any concerns taken through the grievance process for follow-up and resolution. Anyone unable to contact were sent certified letters on July 29, 2014. ◆ Staff was interviewed on July 23 to August 10, 2014 for any abuse, neglect or any misappropriation or concerns by the DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, SCC, BOM, DOA, RSM, QoLD, WCN, WNS, Chaplain and SSD. ◆ Initial reports were completed as well as 5 day follow-up for any concerns identified. Thorough investigations were completed and forwarded on to the state agencies as necessary. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 57</p> <p>Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K".</p> <p>Based on interview, record review, review of the facility's policy and investigation reports, during the 08/01/14 survey, it was determined the facility failed to have an effective system in place to ensure all allegations of abuse, including neglect, were investigated thoroughly to ensure residents were protected from further neglect for five (5) of thirty-seven (37) sampled residents (Residents #5, #26, #27, #28, #29). (Refer to F-224)</p> <p>On 07/03/14, Resident #26, who resided on the South Unit, rang the call bell for incontinence care assistance at approximately 5:30 AM; however was not assisted until approximately 7:45 AM, (two hours and fifteen minutes later). Interview with the day shift State Registered Nursing Assistant (SRNA), who assisted Resident #26 at 7:45 AM, revealed the resident was soaked with urine and covered in bowel movement. Staff interviews further revealed other residents on the South Unit were also left soaked in urine or soiled with bowel movement the morning of 07/03/14, after day shift reported to work at 7:00 AM. These residents included #5, #27, #28, and #29.</p> <p>Review of the facility's investigation revealed only Resident #26's concern and his/her condition on the morning of 07/03/14 was investigated. There was no documented evidence the facility investigated the conditions of Residents #5, #27, #28 and #29 who reportedly had been left urine soaked and soiled the morning of 07/03/14 and no documented evidence an assessment was performed on Residents #5, #27, #28 and #29, who were assessed by the facility as</p>	F 225	<p>Measures taken to assure there will not be a Recurrence</p> <ul style="list-style-type: none"> ◆ Education was completed by the SCC on July 23, 2014 to July 30, 2014 related to abuse, neglect and misappropriation to DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM and Administrator. Training included thorough investigations, ensuring that non-interviewable residents (BIMS less than 8) are assessed, prevention, identification, protection, and reporting as well as providing care per residents individualized care plans. ◆ 100 % of all stakeholder were educated beginning on July 23, 2014 to July 30, 2014 by DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC related to abuse, neglect, misappropriation, incontinence care, and activity of daily living and the answering of call lights. Re-educated all staff on August 25 to September 12, 2014. ◆ Education of abuse, neglect, misappropriation policy will be included in the orientation packet for newly hired employees beginning September 12, 2014. ◆ Post tests were completed for all stakeholders to assure learning and understanding of policy and procedures. 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 58</p> <p>non-interviewable. In addition, the facility failed to assess other non-interviewable residents on the South Unit for possible neglect through skin assessments and failed to interview all staff who had knowledge of the condition the residents were found in, on 07/03/14 at shift change.</p> <p>Additionally, review of the facility's investigation reports revealed a staff interview which indicated a conflict between SRNA #19 and SRNA #21, who were usually scheduled as the night shift SRNAs for the South Unit, on which all the aforementioned residents resided. Even though the conflict was noted in Registered Nurse (RN) #4's/Assistant Director of Nursing's (ADON) written statement in the facility's investigation, there was no documented evidence the facility investigated and interviewed the two (2) SRNAs about the conflict after becoming aware of it during the investigation, or that the facility followed-up and addressed the conflict issue to ensure residents were protected from possible further neglect. Staff interviewed by the State Survey Agency revealed the conflict impacted resident care during the night shift on the South Unit on 07/03/14.</p> <p>The facility's failure to have an effective system in place to ensure all allegations of abuse, including neglect were investigated thoroughly, and to ensure residents were protected from further neglect was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 07/25/14, and was determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 with</p>	F 225	<ul style="list-style-type: none"> ◆ Beginning August 02, 2014, Ten staff inservice questionnaires are being administered daily DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC to ensure continued understanding of abuse and neglect policy and procedure. Results of the questionnaires and tests are to be reviewed by the Administrator, HRD/AIT, SSD or DON. <i>Any Stakeholder unable to satisfy this requirement will be re-educated until satisfactory completion or removed from the schedule if unable to demonstrate understanding upon re-education. This will continue until instructed otherwise by the QA Committee.</i> ◆ Beginning August 02, 2014, five resident skin assessments per day shall be completed by a licensed nurse for residents with BIMS of less than 8. Results will be reviewed by the DON, ADON, SDC, MDSN or WCN daily. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> 		

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

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F 225	<p>Continued From page 59</p> <p>the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure an effective system is in place to ensure all allegations of abuse, including neglect are investigated thoroughly, and residents are protected from further neglect.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse, Neglect and Misappropriation", dated April 2013 revealed abuse and neglect of residents was prohibited. Review of the Policy revealed staff was to be trained on abuse to include what constituted abuse, neglect or misappropriation of resident property. The Policy revealed all allegations of abuse were to be investigated, and the Administrator/designee was to make all reasonable efforts to investigate and address alleged reports, grievances and concerns. Further review revealed Social Services or the Chaplain were to follow up with the resident to monitor his/her emotional well-being after an incident, and families were to be notified of the outcome of the investigation.</p> <p>Interview, 07/03/14 at 2:26 PM, with Resident #26 revealed early that morning the resident had requested night shift SRNA #19's assistance to get cleaned up as he/she had "pooped" on himself/herself. According to Resident #26, SRNA #19 did not assist him/her as requested, which made the resident feel staff "did not want to</p>	F 225	<ul style="list-style-type: none"> ◆ Beginning August 02, 2014, five residents with BIMS greater than 8 will be interviewed daily by DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC and reviewed by the Administrator, HRD/AIT, SSD, or DON. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> ◆ Beginning August 02, 2014, five call light observations will be completed on each shift by the DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 60</p> <p>change" him/her and feel like he/she "wasn't supposed to be clean". Resident #26 was observed to start crying, and stated he/she did not received assistance to be changed until after day shift SRNAs came to work.</p> <p>Interview with SRNA #9 on 07/03/14 at 2:44 PM, revealed when she reported to work for day shift on 07/03/14, she found several residents "soaked" and/or soiled, and needing to be changed (Residents #5, #26, #27, #28, and #29).</p> <p>Review of the facility's investigation reports, dated 07/03/14 through 07/07/14, revealed only Resident #26's concerns were investigated. There was no documented evidence of Resident #5, Resident #27, Resident #28 or Resident #29 being left wet and/or soiled by night shift staff on 07/03/14 was investigated. Continued review of the investigation report revealed Resident #26 was interviewed on 07/03/14 and had concerns about the care received by night shift staff which he/she had reported to Registered Nurse (RN) #5/Evening Shift Supervisor.</p> <p>Interview, on 07/03/14 at 6:45 PM, with RN #5/Evening Shift Supervisor revealed at approximately 4:08 PM that day she had spoken with Resident #26 who told her SRNA #19 had left him/her "wet and with crap" on him/her. RN#5/Evening Shift Supervisor stated she went to the Director of Nursing (DON) and Social Services Director (SSD) and reported to them what Resident #26 had told her.</p> <p>Continued review of the investigation report revealed staff statements were obtained and two (2) staff interviewed, Licensed Practical Nurse (LPN) #12 and RN #4/ADON indicated SRNA #9</p>	F 225	<p>Beginning August 02, 2014, incontinency care observations will be completed for five residents daily licensed nurse and results will be reviewed by the Administrator, DON, ADON, ESNS, WNS or WCN. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i></p> <p>Beginning August-02 September 22, 2014, the Administrator, SSD or DON will review <i>weekly</i>, all grievances and allegations of abuse, neglect and misappropriation to assure all steps of the abuse, neglect policy and procedure were completed. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i></p>		

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

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F 225	<p>Continued From page 61</p> <p>had reported concerns regarding the condition residents were left in by night shift staff on 07/03/14. Review of the written statement for LPN #12 revealed SRNA #9 reported to him her "group" of assigned residents, on the Southeast Hall of the South Unit, were "all wet" when she took over their care. LPN #12 noted in his written statement he told SRNA #9 to "take it to" RN #4/ADON or the DON, and the SRNA "just turned and walked away". Review of RN #4's/ADON's written statement revealed SRNA #9 had stated "late in the day" on 07/03/14 that Resident #26 had reported to her he/she had been "covered in feces up to" his/her waist and no one had changed him/her. RN #4/ADON documented having spoken to SRNA #16 who had sat "one on one" with Resident #26, "since around 6:20" AM. RN #4/ADON noted SRNA #16 told her SRNA #19 (the night shift SRNA) informed her she had not changed Resident #26 because the resident was a two (2) person assist, and she and the "other night shift" aide, SRNA #21 "don't work together". However, continued review of the investigation report revealed no documented evidence SRNA #9 was interviewed by the facility regarding her concerns on 07/03/14.</p> <p>Interview with SRNA #9 on 07/03/14 at 2:44 PM, revealed she had never been interviewed regarding her concerns on 07/03/14, in regards to Resident #5, Resident #26, Resident #27, Resident #28 and Resident #29 being left wet and/or soiled by night shift staff. Even though she had expressed her concerns regarding the residents care to LPN #12 and RN #4/ADON which was documented on their written statements that was part of the investigation conducted 07/03/14 through 07/07/14.</p>	F 225	<ul style="list-style-type: none"> ◆ Beginning September 12, 2014 Residents and families attending care plan conferences shall be asked by the SSD, MDSN, QoLD or Licensed Nurse if there have been any concerns and if grievance process has been initiated and followed. If resident or responsible party does not attend the care plan conference the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain, shall attempt to contact via phone x3 for response. <i>Any identified concerns will be investigated by the SCC, Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. Administrator, HRD/AIT, DON, SCC, ADON or SDC will be responsible for re-education and/or disciplinary action up to and including termination shall occur for any failure to follow the grievance process. This will continue until directed otherwise by the QA Committee.</i> ◆ Investigation relative SRNA conflict was initiated on July 22, 2014 by HRD/AIT, SCC, DON or ADON interviewing stakeholders working July 2-3, 2014 to identify the conflict that had been reported to OIG. Investigation was completed on July 25, 2014 with SRNA #19 being terminated as a result of the investigation. 		

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

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F 225	<p>Continued From page 62</p> <p>Interview, on 07/03/14 at 4:35 PM, with the RN #4/ADON revealed she had not talked directly to SRNA #9; however, indicated she should have. Per interview, RN #4/ADON stated she was not aware of a conflict between SRNA #19 and SRNA #21 at the time of the incident on 07/03/14. She stated if they were not "working well together" it could "impact" resident care.</p> <p>Additionally, review of the facility's investigation report dated 07/03/14 through 07/07/14, revealed staff interviews which indicated a conflict between SRNA #19 and SRNA #21, who were usually scheduled as the night shift SRNAs for the South Unit, on which all the aforementioned residents resided. Even though SRNA #19's phone interview statement revealed she had "difficulty" getting SRNA #21 to help her, and RN #4/ADON's written statement noted SRNA #19 and SRNA #21 didn't "work together", there was no documented evidence the facility interviewed the two (2) SRNAs about the conflict, or that the facility followed-up and addressed the issue to ensure residents were protected from possible further neglect.</p> <p>Interview conducted on 07/23/14 at 9:08 AM, with SRNA #19 revealed the DON had never discussed the incident involving Resident #26, on the morning of 07/03/14, with her. She stated she had never been asked to write a statement about what had occurred, and had never been interviewed by any of the administrative staff. However, review of the investigation report revealed a telephone interview was conducted with SRNA #19 on 07/03/14 by the Human Resources (HR) Director related to Resident #26. Continued interview with SRNA #19 revealed SRNA #21 and she had a conflict between them,</p>	F 225	<p>◆ <i>Conflict Management training was initiated by the HRD/AIT, SCC, DON, ADON, or SDC on 08/29 and was ongoing until 09/12. Topics of discussion were: Conflict management- how to handle it, who to communicate it to if you need help resolving; The Hotline policy and procedure; Attendance policy; Staffing Protocols were also reviewed with the nursing staff only. All those not completed by 09/12 were mailed certified letters that training must be completed prior to working again. Starting the week of September 12, 2014 for 4 weeks, HRD/AIT, SCC, DON, ADON, or SDC have completed stakeholder interviews at random with the nursing staff to address/assist with any stakeholder conflict/teambuilding as necessary.</i></p> <p>Monitoring Changes to Assure Continuing Compliance</p> <p>◆ Results of the staff, resident and family interviews, skin assessments, call light observations, and incontinence care observations will be reported weekly x4 to the QA committee by the ADON, MDSN, SDC, WCN, SSD, DON, Administrator or HRD/AIT to determine further need for continued education, revision of plan and process improvements. Any allegations of abuse, neglect and misappropriation will be handled immediately and then reviewed at the weekly meeting beginning August 06, 2014.</p> <p>Date of Completion: 09-27-14</p>	

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

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F 225	<p>Continued From page 63</p> <p>and therefore did not work together when assigned as the two (2) SRNAs on the night shift for the South Unit. SRNA #19 stated she had told nurses about the conflict, and had written a grievance about the conflict and put it under the DON's office door. However, she stated nothing had ever been done and she had never been interviewed regarding the conflict.</p> <p>Interview, on 07/23/14 at 4:51 PM, with SRNA #21 revealed no one in the facility had ever discussed the incident involving 07/03/14 with her.</p> <p>Further review of the investigation report, dated 07/07/14, revealed Resident #26's concerns/allegation were unsubstantiated, as there were no findings of abuse or neglect. In addition, review of the investigation report revealed no documented evidence other non-interviewable residents also cared for by SRNA #19 on 07/03/14 had been assessed or their families/responsible parties interviewed.</p> <p>A group interview was held with the HR Director, Social Services Director (SSD) and DON on 07/23/14 at 5:49 PM. Per the SSD, she was responsible for abuse investigations. She stated on 07/03/14 the investigation performed had been "focused" on Resident #26's concerns. The SSD indicated she was unaware of a conflict between SRNA #19 and SRNA #21, even though two (2) staff reported concerns in staff interviews conducted on 07/03/14. The SSD reported the investigation report was reviewed by the former Administrator on 07/07/14, in conjunction with herself and the HR Director.</p> <p>Per the HR Director, she had assisted with the</p>	F 225			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 79 and part-time staff.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all interviewed and asked if they were aware of any abuse, neglect, or misappropriation.</p> <p>6. Review of the allegations relative to the interviews with residents, families, responsible parties, and staff concerns revealed they were investigated with initial reports completed.</p> <p>Interview with the Corporate Nurse Consultant on 07/31/14 at 7:08 PM revealed there was several reportable allegations from the interviews which she assisted with conducting, and the facility investigated with follow up actions and reporting.</p> <p>7. Review of the Abuse, Neglect, and Misappropriation audits, assessments, interviews and questionnaires revealed they were reviewed by the DON, Corporate Nurse Consultant, Chief Nurse Executive or Special Projects Administrator on 07/27/14 and 07/28/14.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed they expanded on the abuse questions giving scenarios to the staff to have them choose</p>	F 225			

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

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F 225	<p>Continued From page 80</p> <p>which type of abuse was occurring in the scenarios. She stated she reviewed the abuse audits, assessments, interviews, and questionnaires.</p> <p>8. Review of the Quality Assurance Signature Sheet and Minutes revealed an Emergency QA meeting was held on Saturday, 07/26/14, with the Medical Director, Special Projects Administrator, Director of Nursing Services, Director of Clinical Risk Management, Staff Development, Certified Nurse Executive, Corporate Nurse Consultant, Human Resources Director, and Social Services Director to discuss current Immediate Jeopardy deficiencies and a Plan of Correction.</p> <p>Interview with the DON on 08/01/14 and the Corporate Nurse Consultant on 07/31/14 at 7:08 PM confirmed the QA Meeting was held on 07/26/14 with the Medical Director. Interview with the HR Director on 07/31/14 at 5:45 PM revealed during the emergency QA Meeting they discussed the Immediate Jeopardy deficiencies and the reason for the deficiencies as well as discussed the audits, interviews, questionnaires and interviewing that was being done related to the deficiencies.</p> <p>9. Review of the sign in sheets dated 07/23/14 regarding training for the Administrative staff of the facility regarding the Abuse, Neglect and Misappropriation Policy revealed the Certified Nurse Executive educated the DON, ADON's, MDS Coordinator, SDC, Dietary Director, Business Office Manager, Social Services Director, Chaplain, Admissions Director, Medical Records, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director ,</p>	F 225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 225	<p>Continued From page 81</p> <p>Quality of Life Director and Wound Care Nurse received the training.</p> <p>Review of the sign in sheet on 07/28/14 for training on the Abuse, Neglect and Misappropriation Policy, revealed the Administrator of the facility was educated on skin assessments, interviews, the Abuse, Neglect, and Misappropriation Policy, and the Education session regarding the Plan of Correction.</p> <p>Interview with the ADON/UM of the South Unit on 07/31/14 at 3:30 PM, ADON/UM of the North Unit on 07/31/14 at 4:45 PM, HR Director on 07/31/14 at 5:45 PM, the Dietary Director on 07/31/14 at 6:15 PM, and the DON on 08/01/14 at 10:00 AM, revealed they received training on abuse, neglect and misappropriation and had to take a post test in which they had to score a one hundred percent (100%).</p> <p>Review of the post test administered for Department Administrative Managers revealed a score of one hundred percent (100%) related to abuse, neglect, and misappropriation education.</p> <p>Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant, revealed the Department Administrative Managers scored a one hundred percent (100%) on the post test related to abuse, neglect and misappropriation education.</p> <p>10. Review of the inservices revealed education was conducted with stakeholders related to abuse, neglect, and misappropriation 07/23/14 through 07/28/14 in which they had to score a one hundred percent (100%) on the post test or retake the test.</p>	F 225			

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

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F 225	Continued From page 82 Interview with the Staff Development Coordinator (SDC) on 07/31/14 at 5:15 PM, and the SSD on 07/31/14 at 6:30 PM revealed she and other administrative staff educated the stakeholders related to abuse, neglect and misappropriation and completed these inservices. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated on the facility's Abuse, Neglect and Misappropriation Policy, which included training, prevention, identification, investigation, protection and reporting. Review of the sign in sheets from 07/23/14 through 07/28/14 revealed inservices were conducted with the facility staff regarding the Abuse and Neglect Policy. Review of the post-test revealed some staff had to be re-educated and staff eventually received a one hundred percent (100%) on the post tests. Documentation provided from the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed.	F 225			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 225	<p>Continued From page 83</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated related to abuse, neglect, and misappropriation in which they had to score a one hundred percent (100%) on the post test or retake the test.</p> <p>11. Review of the sign in sheets on 7/26/14 and documentation of education provided revealed additional education was conducted with stakeholders regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner to the facility staff. Review of documentation provided by the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Further review revealed the stakeholders had to score a one hundred percent (100%) on the post test or retake the test. Further review revealed all but four (4) pm (as needed) staff had taken the test and scored a one hundred percent (100)%.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM)</p>	F 225			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 84</p> <p>of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received inservice training regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner.</p> <p>12. Review of the new orientation schedule revealed all new employees will complete education regarding the facility's abuse and neglect and successfully complete post test.</p> <p>Interview with the SDC on 07/31/14 at 5:15 PM confirmed the abuse and neglect education was a part of the new orientation schedule for new employees.</p> <p>13. Review of the Stakeholder Assessment of Knowledge Tests regarding the Abuse, Neglect and Misappropriation Policy revealed the test was administered to five (5) stakeholders each shift and continued with different stakeholders.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34</p>	F 225			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 85</p> <p>at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received the Assessment of Knowledge Test regarding abuse, neglect and misappropriation.</p> <p>14. Review of the questionnaires, skin assessments, and interviews revealed ten (10) stakeholder questionnaires, ten (10) skin assessments for residents with a BIMS of less than eight (8), and ten (10) interviews with residents with a BIMS of eight (8) or greater than eight (8) were administered daily related to understanding of the abuse, neglect, and misappropriation policy. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the DON on 08/01/10 at 10:00 AM revealed, the facility was still administering ten (10) questionnaires to stakeholders a day, performing ten (10) skin assessments a day for residents with a BIMS of less than eight (8), and conducting ten (10) interviews a day with residents who had a BIMS of eight (8) or greater related to abuse, neglect, and misappropriation.</p> <p>15. Review of the QA Minutes dated 07/26/14 revealed the stakeholder questionnaires, resident skin assessments and resident interviews were to be reviewed daily and results and were to be reported to QA weekly.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed the stakeholder questionnaires, skin assessments and resident interviews were reviewed daily by her and taken to the QA</p>	F 225			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 225	<p>Continued From page 86 Meeting weekly.</p> <p>16. Review of the call light audits revealed monitoring was being done twenty-four hours (24) a day on each shift. Further review of the call light audits revealed five (5) call lights audits was being done daily on each shift (fifteen (15) total) which was ongoing. Review of the audits for Incontinence care revealed observation of incontinence care was completed for ten (10) residents daily. Review of the call light audits revealed an improvement in call light response time as the auditing continued.</p> <p>Interview on 07/31/14, with LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; and LPN #13 at 6:05 PM verified, as charge nurses they were providing direct observation of call light responsiveness and ensuring the residents were getting needs met as per the care plan.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed call light audits were still being done twenty-four (24) hours a day on each shift and observation of incontinence care was still being done for ten (10) residents daily and the results of the audits would be taken to the weekly QA Meeting.</p> <p>17. Review of the audits revealed the Human Resources Director conducted an audit of the personnel charts for any history of abuse, neglect, or misappropriation concerns and no concerns were identified.</p> <p>Interview with the HR Director on 07/31/14 at 5:45 PM revealed she had performed an audit of the personnel files looking for any abuse charge,</p>	F 225			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 87</p> <p>coaching/counseling/suspension/termination related to abuse, license verification, criminal background checks and abuse registry checks.</p> <p>18. Observation on 07/31/14 at 11:00 AM revealed a sign was posted by the time clock to personnel to address Caring for the Caregiver - signs of stress and burn-out.</p> <p>Interview with SRNA #24, on 07/31/14 at 2:00 PM, revealed she was aware of the sign at the timeclock related to stress and burn out.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed there was a sign posted by the timeclock for personnel related to what to do if feeling stress and burn out.</p> <p>19. Observation revealed a nurse from the corporate office of the facility was present on the facility throughout the survey.</p> <p>Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant revealed a Corporate Nurse had been in the building since 07/21/14 on someone would remain at the facility until the immediacy was removed.</p> <p>20. Review of the Grievances and Resident Questionnaires since 07/23/14 revealed they were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director and/or Regional Nurse Consultants by 07/28/14. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the Administrator on 08/01/14 at 11:46 AM, revealed he had been reviewing daily</p>	F 225			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 88</p> <p>the grievances, incident reports and resident and staff questionnaires to identify any reportable allegations and the facility was reviewing them daily Monday through Friday in the morning stand up meeting. He stated the DON and SSD were to report any allegations of abuse to him and he was to review the investigations to ensure there was corrective action, appropriate follow up, and reporting.</p> <p>21. Review of the Allegation Log, revealed the following; validate protection of residents, perpetrator removed from resident care area, reports to the Inspector General and APS were filed timely, and a thorough investigation was completed.</p> <p>Interview with the SSD on 07/31/14 at 6:30 PM revealed she was the Abuse Coordinator and she reviewed allegations of abuse and grievances daily with the Administrator. She stated Accident and Incident reports, allegations of abuse/neglect/misappropriation and grievances were reviewed daily in the clinical meeting Monday through Friday with the DON and other Administrative Staff. She stated there was a new tool used for logging investigations which included the date of submission, resident name, description of allegation, perpetrator, date the five (5) day investigation was to be completed, and the date state agencies were notified of the findings. The SSD stated she was responsible for keeping the log up to date with new reportable allegations.</p> <p>22. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation that in the event of any new reports of alleged abuse, neglect, or</p>	F 225		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 89</p> <p>misappropriation the Signature Care Consultant or Chief Nursing Executive would be contacted prior to making the final five day investigation to the State Survey Agency to validate the resident was protected, report was filed timely, the perpetrator was removed from the patient area and a thorough investigation was completed.</p> <p>Interview with the Administrator on 08/01/14 at 11:46 AM, revealed in the event of any allegation of abuse, neglect or misappropriation, corporate was to review the investigation prior to sending the five (5) day final report to the State Survey Agency.</p> <p>23. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation stating care plan conferences would include any abuse, neglect or misappropriation concerns that the families or residents may have.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed all care plan conferences would include questioning residents and families about any concerns related to abuse, neglect or misappropriation.</p> <p>24. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed Corporate Administrative oversight of the facility was to continue until the immediacy was removed, then would continue weekly for four (4) weeks and then monthly.</p> <p>25. Interview on 08/01/14 at 11:46 AM with the Administrator confirmed there would be a weekly QA meeting to include Corporate oversight weekly for four (4) weeks, then monthly and the last meeting was 07/26/14. He stated during the</p>	F 225			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 90 meeting they would discuss the audits and recommendations for frequency of continued audits related to the deficiencies cited.	F 225			
F 226 SS=K	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K". Based on interview, record review, review of the facility's investigation reports and policy, during the 08/01/14 survey, it was determined the facility failed to have an effective system in place to ensure the facility's policies and procedures	F 226	F 226 Immediate Corrective Action for Residents Found To Be Affected ♦ On July 23 to July 25, 2014 residents #5, 26, 27, 28, and 29 had investigations opened related to allegations of neglect and initial reports were completed as well as 5 day follow-up reports to all appropriate state agencies. SSD met with each of the residents to assess for any issues or complaints. Identification of Other Residents with the Potential to be affected ♦ 100% of the resident population received head to toe assessments on July 23 to July 28, 2014 by the DON, ADON, MDSN, WCN, SDC, ESNS, SCC or licensed nurses. ♦ All residents with BIMs of 8 or above were interviewed on July 23 to July 25, 2014 by SSD, HRD/AIT, QoLD, QoLA, MRM, Chaplain, BOM, DOA, ADON, SDC, SCC : and ESNS with any concerns voiced taken through the grievance process for follow-up and resolution. ♦ All residents with a BIMS below 8, Responsible Parties, POA or Guardian were interviewed on July 23 to August 04, 2014 by SSD, HRD/AIT, DOA, MRM, Chaplain, BOM, ABOM, ESD, DSM, SCC, ADON,		

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

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F 226	<p>Continued From page 91</p> <p>related to abuse/neglect were implemented for five (5) of thirty-seven (37) sampled residents (Residents #5, #26, #27, #28, #29). On 07/03/14, at approximately 5:30 AM, Resident #26 rang his/her call light to request assistance, from the night shift staff, to be cleaned after being incontinent. However, Resident #26 did not receive the requested assistance until approximately 7:45 AM, when the day shift State Registered Nursing Assistants (SRNAs) assisted the resident. Interviews with the day shift SRNAs revealed Resident #26 was covered in bowel movement (BM) and urine soaked when they assisted the resident. Interviews with the day shift staff revealed other residents were also left urine soaked or soiled with BM that same morning, 07/03/14. The other residents included Resident #5, Resident #27, Resident #28 and Resident #29. (Refer to F-224, F-225)</p> <p>Additionally, during the facility's investigation a conflict was identified between the two (2) night shift SRNAs usually assigned to care for the residents involved, who did not work together when providing care for residents. However, the facility failed to address the conflict between the SRNAs which impacted resident care on night shift on the South Unit, where the residents all resided, leaving residents at risk for further neglect.</p> <p>In addition, review of the facility's policy and procedure related to abuse and neglect revealed the policy did not clearly state all allegations of abuse would be investigated per the regulation, F-225.</p> <p>The facility's failure to have an effective system in place to ensure the implementation of abuse</p>	F 226	<p>QoLA and QoLD with any concerns taken through the grievance process for follow-up and resolution. Anyone unable to contact were sent certified letters on July 29, 2014.</p> <ul style="list-style-type: none"> Staff was interviewed on July 23 to August 10, 2014 for any abuse, neglect or any misappropriation or concerns by the DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, SCC, BOM, DOA, RSM, QoLD, WCN, WNS, Chaplain and SSD. Initial reports were completed as well as 5 day follow-up for any concerns identified. Thorough investigations were completed and forwarded on to the state agencies as necessary. <p>Measures taken to assure there will not be a Recurrence</p> <ul style="list-style-type: none"> Education was completed by the SCC on July 23 to July 30, 2014 related to <i>current corporate policies, which was previously approved by CMS and states on page 1, "all allegations of abuse will be investigated" and government regulations on abuse, neglect and misappropriation to DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM and Administrator. Training included investigations, prevention, identification, protection, and reporting as well as, providing care per residents individualized care plans.</i> 		

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F 226	<p>Continued From page 92</p> <p>policies and procedures to prevent neglect was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 07/25/14, and determined to exist on 07/03/14. The facility was notified of the Immediate Jeopardy on 07/25/14.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14, with the facility alleging removal of the Immediate Jeopardy on 07/29/14. The Immediate Jeopardy was verified to be removed on 07/29/14, prior to exiting the facility on 08/01/14, with remaining non-compliance at a Scope and Severity of a "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure an effective system is in place to ensure abuse policies and procedures are implemented to prevent neglect of residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse, Neglect and Misappropriation", dated April 2013 revealed the facility prohibited abuse or neglect of residents. Review of the Policy revealed staff was to be trained on abuse to include what constituted abuse, neglect or misappropriation of resident property. The Policy revealed all allegations of abuse were to be investigated, and the Administrator/designee was to make all reasonable efforts to investigate and address alleged reports, grievances and concerns. Further review revealed Social Services or the Chaplain were to follow up with the resident to monitor his/her emotional well-being after an incident, and families were to be notified of the outcome of the investigation.</p>	F 226	<ul style="list-style-type: none"> ♦ 100 % of all stakeholder were educated beginning on July 23, 2014 to July 30, 2014 by DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC related to <i>current corporate policies (which was approved by CMS and states on page 1, "all allegations of abuse will be investigated"), and government regulations on abuse, neglect, misappropriation incontinence care, and activity of daily living and the answering of call lights. Re-educated all staff on August 25 to September 12, 2014.</i> ♦ Education of abuse, neglect, misappropriation policy will be included in the orientation packet for newly hired employees beginning September 12, 2014. Post tests were completed for all stakeholders to assure learning and understanding of policy and procedures. ♦ Beginning August 02, 2014, Ten staff inservice questionnaires are being administered daily DON, ADON, MDSN, SDC, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC to ensure continued understanding of abuse and neglect policy and procedure. Results of the questionnaires and tests are to be reviewed by the Administrator, HRD/AIT, SSD or DON. <i>Any Stakeholder unable to satisfy this requirement will be re-educated until satisfactory completion or removed from the schedule if unable to demonstrate understanding upon re-</i> 		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 226	Continued From page 93 Post-survey interview with the current Administrator, on 08/12/14 at 4:40 PM, revealed where the facility's abuse policy stated the Administrator/designee was to make reasonable effort to investigate and address allegations of abuse or neglect meant "doing whatever" it took to "find out the circumstances" of an incident. He stated all investigations were to be investigated and reported, and all efforts made to address all investigations, allegations, concerns or grievances. However, he indicated the policy wording was confusing, and indicated the wording in the policy needed to be changed to clearly state all allegations of abuse would be investigated as per the regulation. Review of the facility's investigation report forms dated 07/03/14, and documented as concluded on 07/07/14, revealed Resident #26 had voiced concerns related to "possible" failure by a night shift SRNA to provide care. Review of the staff's written statements and interviews revealed staff interviewed during the investigation reported Resident #5, Resident #27, Resident #28 and Resident #29 had also been left wet and/or soiled the morning of 07/03/14. However, continued review of the statements and staff interviews revealed no documented evidence Resident #5, Resident #27, Resident #28 and Resident #29 were assessed or staff concerns were investigated or followed-up on related to these residents as per facility policy. Additional review of the staff interviews and written statements in the investigation report revealed two (2) staff had reported SRNA #9 had voiced concerns regarding resident care issues on 07/03/14, and staff also, indicated there was a conflict between SRNA #19 and SRNA #21 who worked on night shift.	F 226	<p><i>education. This will continue until instructed otherwise by the QA Committee.</i></p> <ul style="list-style-type: none"> ◆ <i>Investigation relative SRNA conflict was initiated on July 22, 2014 by HRD/AIT, SCC, DON or ADON interviewing stakeholders working July 2-3, 2014 to identify the conflict that had been reported to OIG. Investigation was completed on July 25, 2014 with SRNA #19 being terminated as a result of the investigation.</i> ◆ <i>Conflict Management training was initiated by the HRD/AIT, SCC, DON, ADON, or SDC on 08/29 and was ongoing until 09/12. Topics of discussion were: Conflict management- how to handle it, who to communicate it to if you need help resolving; The Hotline policy and procedure; Attendance policy; Staffing Protocols were also reviewed with the nursing staff only. All those not completed by 09/12 were mailed certified letters that training must be completed prior to working again. Starting the week of 9/12 for 4 weeks, HRD/AIT, SCC, DON, ADON, or SDC have completed stakeholder interviews at random with the nursing staff to address/assist with any stakeholder conflict/teambuilding as necessary.</i> ◆ <i>Beginning August 02, 2014, five resident skin assessments per day shall be completed by a licensed nurse for residents with BIMS of less than 8. Results will be reviewed by the DON, ADON, SDC, MDSN or WCN daily. Any identified concerns will be investigated by the Administrator, DON,</i> 		

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

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3578 PIMLICO PARKWAY LEXINGTON, KY 40517	
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F 226	<p>Continued From page 94</p> <p>However, there was no documented evidence SRNA #9 was interviewed regarding her concerns and no documented evidence the facility had addressed the conflict reported between SRNA #19 and SRNA #21 to ensure an investigation was conducted to prevent neglect as per facility policy.</p> <p>Interview on 07/23/14 at 5:49 PM, with the Human Resources (HR) Director, Social Services Director (SSD) and Director of Nursing (DON) revealed the investigation conducted on 07/03/14 had been "focused" on Resident #26's concerns. The HR Director stated she interviewed the staff she thought had been assigned to the residents the morning of 07/03/14; however, she was not sure why SRNA #9 was not interviewed. Further interview revealed even though she had assisted with the investigation performed 07/03/14 through 07/07/14 where staff interviewed indicated a conflict between SRNA #19 and SRNA #21, she was not aware of a conflict between the two (2) SRNAs. The HR Director stated she had missed the information in staff's statements she obtained on 07/03/14, such as, SRNA #9's concerns reported to two (2) staff regarding resident care, and the conflict between SRNA #19 and SRNA #21. In interview, the DON stated after completion of the investigation on 07/07/14, she had not reviewed the investigation report. According to the DON, she was not aware of SRNA #9's concerns reported during the investigation; however, she stated the investigation should have noted why the staff had not taken action, when the SRNA expressed concerns regarding resident care to staff.</p> <p>However, interview, on 07/31/14 at 10:14 AM, with the former Administrator, who was in charge</p>	F 226	<p><i>ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i></p> <ul style="list-style-type: none"> Beginning August 02, 2014, five residents with BIMS greater than 8 will be interviewed daily by DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC and reviewed by the Administrator, HRD/AIT, SSD, or DON. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> Beginning August 02, 2014, five call light observations will be completed on each shift by the DON, ADON, MDSN, SDC, ESNS, WNS, DSM, BOM, SSD, Chaplain, DOA, MRM, HRD/AIT, RSM, QoLA, ESD, POD, QoLD, WCN, BOM, Administrator, or SCC. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> 	

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

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OMB NO. 0938-0391

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F 226	Continued From page 95 of the facility until 07/11/14, revealed the DON did make her aware of the conflict between SRNA #19 and SRNA #21. However, she failed to follow-up on it during the investigation conducted on 07/03/14. She stated the conflict could have impacted resident care if the SRNAs did not work together. She further revealed the HR Director or Staff Development Nurse (SDN) should have addressed the conflict, as per facility policy. The former Administrator stated the DON, the HR Director and SSD had performed the investigation, and her part of the investigation had been to review it and come up with findings; however, the investigation information was verbally reported to her and she had not read the investigation report. The former Administrator indicated as Administrator she should have ensured a thorough investigation was performed to include: interviewing SRNA #9's regarding her concerns of residents left wet and/or soiled on 07/03/14; ensuring those residents were assessed; ensuring the interviewable residents concerns were investigated; and ensuring the conflict between SRNA #19 and SRNA #21 was investigated and addressed as per the policy. Interview, on 07/31/14 at 11:47 AM, with the current Administrator revealed he had taken over as Administrator on 07/11/14, and indicated he was aware of the facility's abuse policy, he had been involved in investigations, and was aware of the status of investigations. He stated as Administrator he read the final investigation reports, and findings were also verbally reported to him by staff involved in the investigations. The current Administrator stated this process was in place prior to his taking over as Administrator of the facility. However, interview and record review revealed the process/procedure had not	F 226	<ul style="list-style-type: none"> ◆ Beginning August 02, 2014, incontinency care observations will be completed for five residents daily licensed nurse and results will be reviewed by the Administrator, DON, ADON, ESNS, WNS or WCN. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> ◆ Beginning August 02 September 22, 2014, the Administrator, SSD or DON will review <i>weekly</i>, all grievances and allegations of abuse, neglect and misappropriation to assure all steps of the abuse, neglect policy and procedure were completed. <i>Any identified concerns will be investigated by the Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. This will continue until directed otherwise by the QA Committee.</i> ◆ Beginning September 12, 2014 Residents and families attending care plan conferences shall be asked by the SSD, MDSN, QoLD or Licensed Nurse if there have been any concerns and if grievance process has been initiated and followed. If resident or responsible party does not attend the care plan conference the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, 		

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

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F 226	<p>Continued From page 96 been implemented.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 that alleged removal of the IJ effective 07/29/14. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. The facility opened and investigated the five (5) reported allegations of neglect identified on the 06/30/14 through 07/03/14 Survey for Residents #5, #26, #27, #28, and #29. Initial Reports were completed with the five (5) day follow up reports pending completion of the investigations. The allegations were investigated by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant. 2. One hundred percent (100%) of the resident population received head to toe assessments by the DON, the ADON, MDS Coordinator, Wound Care Nurse, SDC, Evening Nurse Supervisor, Corporate Nurse Consultant and Charge Nurses on 07/23/14. 3. Residents with a BIMS of eight (8) or above were interviewed by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Supply Coordinator, Quality of Life Director or Chaplain which was completed on 07/25/14 for any abuse, neglect, or misappropriation concerns. 4. Families and responsible parties were interviewed for residents with a BIMS below eight 	F 226	<p>WNS, SSD, Administrator or Chaplain. shall attempt to contact via phone x3 for response. <i>Any identified concerns will be investigated by the SCC, Administrator, DON, ADON, SDC, HRD/AIT, SSD or DOA for root cause with appropriate follow up and reporting to state agencies as per policy and regulatory requirements. Administrator, HRD/AIT, DON, SCC, ADON or SDC will be responsible for re-education and/or disciplinary action up to and including termination shall occur for any failure to follow the grievance process. This will continue until directed otherwise by the QA Committee.</i></p> <p>Monitoring Changes to Assure Continuing Compliance</p> <ul style="list-style-type: none"> ◆ Results of the staff, resident and family interviews, skin assessments, call light observations, and incontinence care observations will be reported weekly x4 to the QA committee by the ADON, MDSN, SDC, WCN, SSD, DON, Administrator or HRD/AIT to determine further need for continued education, revision of plan and process improvements. Any allegations of abuse, neglect and misappropriation will be handled immediately and then reviewed at the weekly meeting beginning August 06, 2014. <p>Date of Completion: 09/27/14</p>		

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

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F 226	<p>Continued From page 97</p> <p>(8) which was initiated on 07/25/14 and as of 07/28/14, thirty-seven (37) of fifty-six (56) had been completed, for any abuse, neglect, or misappropriation concerns. The facility would continue to attempt contacting families and responsible parties daily to identify any concerns until remaining Power of Attorney's (POA's) had been reached. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>5. Staff was interviewed for any abuse, neglect, or misappropriation concerns by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Quality of Life Director or Chaplain on 07/25/14. Initial reports were made on the allegations relative to those interviews.</p> <p>6. Initial Reports were made on 07/25/14 related to the alleged allegations relative to the interviews with residents, families, responsible parties, and staff. Thorough investigations were initiated on 07/25/14 by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant on those residents identified with appropriate follow up reporting on the allegations received.</p> <p>7. Abuse, neglect and misappropriation audits, assessments, interviews and questionnaires were reviewed by the Special Projects Administrator, DON, Corporate Nurse Consultant or Chief Nurse Executive on 07/27-07/28/14 for any indications of abuse, neglect or misappropriation concerns.</p>	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	<p>Continued From page 98</p> <p>8. The Medical Director was notified of the Immediate Jeopardy on 07/25/14 by the DON and Special Projects Administrator. An Emergency Quality Assurance (QA) Meeting was held on 07/26/14 with the Corporate Director of Risk Management, Clinical Nurse Executive, Corporate Nurse Consultant, Medical Director, Special Projects Administrator, DON, HR Director, SSD and SDC related to the Immediate Jeopardy.</p> <p>9. The DON, two (2) ADONs, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions, Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse were re-educated on 07/23/14 and the Administrator was re-educated on 07/28/14, upon his return, by the Corporate Nurse Consultant on the Abuse, Neglect and Misappropriation Policy and Procedure which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans. They could not return to work until the abuse, neglect, misappropriation education was provided and post test administered and a one hundred percent (100%) score was obtained on the post test. If a manager did not score a one hundred percent (100%) on post test, the manager was immediately re-educated and a post test was re-administered.</p> <p>10. The facility's Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director,</p>	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	<p>Continued From page 99</p> <p>HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse educated stakeholders related to the Abuse, Neglect, and Misappropriation Policy which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans starting on 07/23/14 and continued until 07/28/14. No staff would be allowed to work until this education was provided and the post test administered and a one hundred percent (100%) score obtained. Eighty-seven (87) of ninety-six (96) were completed by 07/28/14.</p> <p>11. Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse provided education to stakeholders which was initiated on 07/26/14 to nursing staff related to incontinence care and Activities of Daily Living (ADL's) care per the Care Plan and answering call lights. Calls and certified letters had been sent notifying staff they must complete training before returning to work relative to incontinence care and Activities of Daily Living (ADL's) Care per resident individualized Care Plan and answering call lights in a timely manner.</p> <p>12. Education regarding the Abuse, Neglect and Misappropriation Policy would be included in the orientation process for newly hired staff. No newly hired person would be able to work until this education was provided and a post test</p>	F 226			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 100</p> <p>administered and one hundred percent (100%) score obtained provided by staff development.</p> <p>13. Staff assessment of knowledge test regarding abuse, neglect and misappropriation was being administered by the Administrator, DON, ADON's, MDS Coordinator, SDC, Dietary Director, Medical Records Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse to five (5) staff members on each shift and different staff members until the immediacy was removed.</p> <p>14. Ten (10) staff questionnaires would be administered daily to ensure continued understanding of the Abuse, Neglect and Misappropriation Policy. Results of the questionnaires, tests, ten (10) resident skin assessments of residents with a BIMS less than eight (8) per day, ten (10) residents with a BIMS greater than eight (8) interviews would be reviewed daily until the immediacy was resolved by the Administrator, DON, Nurse Consultant or Chief Nurse Executive. Any concerns revealed on the above to include injuries of unknown source would be reported immediately to the Abuse Coordinator, Administrator, DON, Corporate Nurse Coordinator, Regional Vice President of Operations, Special Projects Administrator, or Chief Nurse Executive.</p> <p>15. Results of the staff questionnaires, resident interviews and skin assessments would be reviewed daily by the Administrator, DON, Nurse Consultant or Chief Nurse Executive with results</p>	F 226			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	Continued From page 101 reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of plan. Based on the evaluation the QA Committee would decide at what frequency the staff questionnaire would need to continue. Concerns identified would be corrected immediately and reported to the Administrator or DON to ensure an investigation of suspected abuse, neglect or misappropriation was investigated/completed and reporting guidelines were met along with any reporting of violation of resident rights. 16. Administrator, DON, ADONs, MDS Coordinator, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Director, Plant Operations Director, Quality of Life Director, Wound Care Nurse, Corporate Nurse Consultant, Regional Vice President or Clinical Nurse Executive would conduct call light audits through direct observation and monitoring tool daily twenty-four (24) hours a day seven (7) days a week on each shift to monitor compliance until the immediacy was removed. Then five (5) call lights daily on each shift (fifteen (15) total) ongoing and reported to QA Committee weekly during immediacy and monthly after immediacy was removed. Charge Nurses would provide direct observation of call light responsiveness and ensure all residents were getting needs met for plan of care each shift. Incontinence care observation would be completed for ten (10) residents daily until the immediacy was removed then ongoing for five (5) residents daily with results being reported to the QA Committee weekly during immediacy and monthly after the	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	<p>Continued From page 102 immediacy was removed.</p> <p>17. Human Resources (HR) Director performed an audit of staff files for any abuse, neglect or misappropriation concerns 7/26/14 through 7/27/14 and the items reviewed included coaching, counseling forms, suspension forms, termination forms, abuse registry checks, background checks and licensure to 07/03/14. Results of the audit was given to the Administrator, DON or Corporate Nurse Consultant on 07/27/14, to review for any abuse, neglect or misappropriation concerns that needed reported. None were identified.</p> <p>18. Information on "Caring for the Caregiver" which addresses the signs of stress and burn out, showing the caregiver ways to cope and reduce stress and useful ways that friends could offer help to the caregiver were posted by the time clock on 07/27/14 by the Special Projects Administrator.</p> <p>19. A nurse from the regional team or corporate office had been onsite since 07/21/14 and would remain in the facility daily until the Immediate Jeopardy was lifted. The nurses from the regional team home office were assisting with investigations, observing staff treatment of residents, performing chart audits and providing oversight and consultation. The Chief Nurse Executive would be in daily contact with the Corporate Nurse Consultant and would review allegations.</p> <p>20. Grievances and Resident Questionnaires since 07/23/14 were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director or Regional Nurse</p>	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	Continued From page 103 Consultants 07/27/14 through 07/28/14 to determine if any items documented were a reportable event. All issues identified were reported and investigations initiated per the facility's policy and procedure. The Administrator, SSD, or the DON would review daily, the grievances and Incident/Accident Reports, until immediacy was lifted, starting 07/27/14 to determine if there were reportable allegations which had been identified, then daily Monday through Friday during the Morning Stand-Up Meeting. SSD or the DON would report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator would review any allegations of abuse, neglect or misappropriation for reporting to the Office of Inspector General, Adult Protective Services and Ombudsman and appropriate authorities as required by state law. 21. The Administrator, DON, SSD would review and discuss abuse, neglect and misappropriation allegations daily to ensure the resident was protected, the perpetrator was removed from resident care area, reports to the State Survey Agency, APS and Ombudsman were filed timely, and a thorough investigation was completed. The Abuse Coordinator (SSD) would maintain an log starting on 07/27/14 that would include documentation of the following: validate protection of residents; perpetrator was removed from resident care area; reports to the State Survey Agency and Adult Protective Services (APS) were filed timely; and a thorough investigation was completed. The Abuse Coordinator and one of the following: Administrator, DON, Chief Nurse Executive or Regional Nurse Consultant would review the	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	<p>Continued From page 104</p> <p>abuse, neglect and misappropriation log daily until removal of the Immediate Jeopardy, beginning on 07/27/14, to validate protection of the resident, that the perpetrator was removed from the resident care area, that reports to the State Survey Agency and APS and appropriate authorities required by state law, were filed timely, and a thorough investigation had been completed.</p> <p>22. In the event of any new reports of alleged abuse, neglect, or misappropriation of property, after the Immediate Jeopardy was removed, the Signature Care Consultant or Chief Nursing Executive would validate the resident was protected, report was filed timely, the perpetrator was removed from resident care area and a thorough investigation was completed.</p> <p>23. Beginning on 07/27/14, the care plan conferences for each resident would include any abuse, neglect or misappropriation concerns which the residents or families had. Resident safety would be validated and then the allegation would be reported to the Charge Nurse. The Abuse, Neglect and Misappropriation Policy would then be followed.</p> <p>24. Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, Chief Nursing Officer, Signature Care Consultant, member of the regional staff team or Chief Operating Officer daily until removal of the immediacy beginning 07/21/14, then weekly for four (4) weeks, then monthly.</p> <p>25. A Quality Assurance Meeting would be held weekly for four (4) weeks beginning 07/26/14,</p>	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	<p>Continued From page 105</p> <p>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.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the facilities investigations revealed the five (5) reported allegations involving Resident's #5, #27, #28, and #29 have been completed with a five (5) day follow up. A re-investigation was done related to allegations for Resident #26.</p> <p>Interview, on 07/31/14 at 7:08 PM, with the Corporate Nurse Consultant revealed the facility had investigated the allegations regarding Resident's #5, #26, #27, #28, and #29 and found them all to be substantiated.</p> <p>2. Review of copies of resident head to toe assessments revealed all residents were assessed and the assessments were performed on 07/23/14 on North and South Hall, with a recorded census on 07/23/14 of fifty six (56) residents on North Hall and fifty-one (51) residents on South Hall. There was no concerns revealed during review of the skin assessments.</p> <p>Interview, on 07/31/14 at 5:26 PM, with the Wound Care Nurse revealed she was in charge of the skin assessments, and she and other nurses completed skin assessments on one hundred percent (100%) of the residents in the building.</p> <p>3. Review of Resident Interviews revealed</p>	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 106</p> <p>residents with a BIMS of eight (8) and above were interviewed, which included forty-six (46) residents, related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>4. Review of family interviews for residents with a BIMS of less than eight (8) revealed thirty-seven (37) of fifty-six (56) of these interviews were completed as of 7/28/14 related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed the interviewable residents were interviewed, as well as, the families of residents with a BIMS score of less than eight (8) and she reviewed the interviews for any concerns.</p> <p>5. Review of the Stakeholder (Staff) Investigative Interviews revealed they were conducted in reference to abuse, neglect and misappropriation concerns 7/23/14 through 7/25/14 for all regular and part-time staff.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at</p>	F 226			

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

PRINTED: 09/02/2014
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OMB NO. 0938-0391

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F 226	<p>Continued From page 107</p> <p>6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all interviewed and asked if they were aware of any abuse, neglect, or misappropriation.</p> <p>6. Review of the allegations relative to the interviews with residents, families, responsible parties, and staff concerns revealed they were investigated with initial reports completed.</p> <p>Interview with the Corporate Nurse Consultant on 07/31/14 at 7:08 PM revealed there was several reportable allegations from the interviews which she assisted with conducting, and the facility investigated with follow up actions and reporting.</p> <p>7. Review of the Abuse, Neglect, and Misappropriation audits, assessments, interviews and questionnaires revealed they were reviewed by the DON, Corporate Nurse Consultant, Chief Nurse Executive or Special Projects Administrator on 07/27/14 and 07/28/14.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed they expanded on the abuse questions giving scenarios to the staff to have them choose which type of abuse was occurring in the scenarios. She stated she reviewed the abuse audits, assessments, interviews, and questionnaires.</p> <p>8. Review of the Quality Assurance Signature Sheet and Minutes revealed an Emergency QA meeting was held on Saturday, 07/26/14, with the Medical Director, Special Projects Administrator, Director of Nursing Services, Director of Clinical Risk Management, Staff Development, Certified Nurse Executive, Corporate Nurse Consultant, Human Resources Director, and Social Services</p>	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 108</p> <p>Director to discuss current Immediate Jeopardy deficiencies and a Plan of Correction.</p> <p>Interview with the DON on 08/01/14 and the Corporate Nurse Consultant on 07/31/14 at 7:08 PM confirmed the QA Meeting was held on 07/26/14 with the Medical Director. Interview with the HR Director on 07/31/14 at 5:45 PM revealed during the emergency QA Meeting they discussed the Immediate Jeopardy deficiencies and the reason for the deficiencies as well as discussed the audits, interviews, questionnaires and interviewing that was being done related to the deficiencies.</p> <p>9. Review of the sign in sheets dated 07/23/14 regarding training for the Administrative staff of the facility regarding the Abuse, Neglect and Misappropriation Policy revealed the Certified Nurse Executive educated the DON, ADON's, MDS Coordinator, SDC, Dietary Director, Business Office Manager, Social Services Director, Chaplain, Admissions Director, Medical Records, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse received the training.</p> <p>Review of the sign in sheet on 07/28/14 for training on the Abuse, Neglect and Misappropriation Policy, revealed the Administrator of the facility was educated on skin assessments, interviews, the Abuse, Neglect, and Misappropriation Policy, and the Education session regarding the Plan of Correction.</p> <p>Interview with the ADON/UM of the South Unit on 07/31/14 at 3:30 PM, ADON/UM of the North Unit</p>	F 226			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 226	<p>Continued From page 109</p> <p>on 07/31/14 at 4:45 PM, HR Director on 07/31/14 at 5:45 PM, the Dietary Director on 07/31/14 at 6:15 PM, and the DON on 08/01/14 at 10:00 AM, revealed they received training on abuse, neglect and misappropriation and had to take a post test in which they had to score a one hundred percent (100%).</p> <p>Review of the post test administered for Department Administrative Managers revealed a score of one hundred percent (100%) related to abuse, neglect, and misappropriation education.</p> <p>Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant, revealed the Department Administrative Managers scored a one hundred percent (100%) on the post test related to abuse, neglect and misappropriation education.</p> <p>10. Review of the inservices revealed education was conducted with stakeholders related to abuse, neglect, and misappropriation 07/23/14 through 07/28/14 in which they had to score a one hundred percent (100%) on the post test or retake the test.</p> <p>Interview with the Staff Development Coordinator (SDC) on 07/31/14 at 5:15 PM, and the SSD on 07/31/14 at 6:30 PM revealed she and other administrative staff educated the stakeholders related to abuse, neglect and misappropriation and completed these inservices.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at</p>	F 226			

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

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F 226	<p>Continued From page 110</p> <p>3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated on the facility's Abuse, Neglect and Misappropriation Policy, which included training, prevention, identification, investigation, protection and reporting.</p> <p>Review of the sign in sheets from 07/23/14 through 07/28/14 revealed inservices were conducted with the facility staff regarding the Abuse and Neglect Policy. Review of the post-test revealed some staff had to be re-educated and staff eventually received a one hundred percent (100%) on the post tests. Documentation provided from the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all</p>	F 226		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 111</p> <p>educated related to abuse, neglect, and misappropriation in which they had to score a one hundred percent (100%) on the post test or retake the test.</p> <p>11. Review of the sign in sheets on 7/26/14 and documentation of education provided revealed additional education was conducted with stakeholders regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner to the facility staff. Review of documentation provided by the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Further review revealed the stakeholders had to score a one hundred percent (100%) on the post test or retake the test. Further review revealed all but four (4) prn (as needed) staff had taken the test and scored a one hundred percent (100)%.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received inservice training regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner.</p>	F 226			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 112 12. Review of the new orientation schedule revealed all new employees will complete education regarding the facility's abuse and neglect and successfully complete post test. Interview with the SDC on 07/31/14 at 5:15 PM confirmed the abuse and neglect education was a part of the new orientation schedule for new employees. 13. Review of the Stakeholder Assessment of Knowledge Tests regarding the Abuse, Neglect and Misappropriation Policy revealed the test was administered to five (5) stakeholders each shift and continued with different stakeholders. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received the Assessment of Knowledge Test regarding abuse, neglect and misappropriation. 14. Review of the questionnaires, skin assessments, and interviews revealed ten (10) stakeholder questionnaires, ten (10) skin assessments for residents with a BIMS of less than eight (8), and ten (10) interviews with	F 226			

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: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 226	<p>Continued From page 113</p> <p>residents with a BIMS of eight (8) or greater than eight (8) were administered daily related to understanding of the abuse, neglect, and misappropriation policy. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the DON on 08/01/10 at 10:00 AM revealed, the facility was still administering ten (10) questionnaires to stakeholders a day, performing ten (10) skin assessments a day for residents with a BIMS of less than eight (8), and conducting ten (10) interviews a day with residents who had a BIMS of eight (8) or greater related to abuse, neglect, and misappropriation.</p> <p>15. Review of the QA Minutes dated 07/26/14 revealed the stakeholder questionnaires, resident skin assessments and resident interviews were to be reviewed daily and results and were to be reported to QA weekly.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed the stakeholder questionnaires, skin assessments and resident interviews were reviewed daily by her and taken to the QA Meeting weekly.</p> <p>16. Review of the call light audits revealed monitoring was being done twenty-four hours (24) a day on each shift. Further review of the call light audits revealed five (5) call lights audits was being done daily on each shift (fifteen (15) total) which was ongoing. Review of the audits for Incontinence care revealed observation of incontinence care was completed for ten (10) residents daily. Review of the call light audits revealed an improvement in call light response time as the auditing continued.</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
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F 226	Continued From page 114 Interview on 07/31/14, with LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; and LPN #13 at 6:05 PM verified, as charge nurses they were providing direct observation of call light responsiveness and ensuring the residents were getting needs met as per the care plan. Interview with the DON on 08/01/14 at 10:00 AM, revealed call light audits were still being done twenty-four (24) hours a day on each shift and observation of incontinence care was still being done for ten (10) residents daily and the results of the audits would be taken to the weekly QA Meeting. 17. Review of the audits revealed the Human Resources Director conducted an audit of the personnel charts for any history of abuse, neglect, or misappropriation concerns and no concerns were identified. Interview with the HR Director on 07/31/14 at 5:45 PM revealed she had performed an audit of the personnel files looking for any abuse charge, coaching/counseling/suspension/termination related to abuse, license verification, criminal background checks and abuse registry checks. 18. Observation on 07/31/14 at 11:00 AM revealed a sign was posted by the time clock to personnel to address Caring for the Caregiver - signs of stress and burn-out. Interview with SRNA #24, on 07/31/14 at 2:00 PM, revealed she was aware of the sign at the timeclock related to stress and burn out.	F 226		

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F 226	<p>Continued From page 115</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed there was a sign posted by the timeclock for personnel related to what to do if feeling stress and burn out.</p> <p>19. Observation revealed a nurse from the corporate office of the facility was present on the facility throughout the survey.</p> <p>Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant revealed a Corporate Nurse had been in the building since 07/21/14 on someone would remain at the facility until the immediacy was removed.</p> <p>20. Review of the Grievances and Resident Questionnaires since 07/23/14 revealed they were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director and/or Regional Nurse Consultants by 07/28/14. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the Administrator on 08/01/14 at 11:46 AM, revealed he had been reviewing daily the grievances, incident reports and resident and staff questionnaires to identify any reportable allegations and the facility was reviewing them daily Monday through Friday in the morning stand up meeting. He stated the DON and SSD were to report any allegations of abuse to him and he was to review the investigations to ensure there was corrective action, appropriate follow up, and reporting.</p> <p>21. Review of the Allegation Log, revealed the following; validate protection of residents, perpetrator removed from resident care area,</p>	F 226			

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F 226	<p>Continued From page 116 reports to the Inspector General and APS were filed timely, and a thorough investigation was completed.</p> <p>Interview with the SSD on 07/31/14 at 6:30 PM revealed she was the Abuse Coordinator and she reviewed allegations of abuse and grievances daily with the Administrator. She stated Accident and Incident reports, allegations of abuse/neglect/misappropriation and grievances were reviewed daily in the clinical meeting Monday through Friday with the DON and other Administrative Staff. She stated there was a new tool used for logging investigations which included the date of submission, resident name, description of allegation, perpetrator, date the five (5) day investigation was to be completed, and the date state agencies were notified of the findings. The SSD stated she was responsible for keeping the log up to date with new reportable allegations.</p> <p>22. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation that in the event of any new reports of alleged abuse, neglect, or misappropriation the Signature Care Consultant or Chief Nursing Executive would be contacted prior to making the final five day investigation to the State Survey Agency to validate the resident was protected, report was filed timely, the perpetrator was removed from the patient area and a thorough investigation was completed.</p> <p>Interview with the Administrator on 08/01/14 at 11:46 AM, revealed in the event of any allegation of abuse, neglect or misappropriation, corporate was to review the investigation prior to sending the five (5) day final report to the State Survey</p>	F 226			