STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185136	A. BUILDING _____ B. WING _____	C 09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey KY#17161 was conducted 09/28 - 09/29/11 and an extended survey 09/29/11. Immediate Jeopardy (IJ) was identified on 09/29/11 and determined to exist on 09/05/11 and is ongoing in 42 CFR 483.13 Resident Behavior and Facility Practices F225, F226, 42 CFR 483.20 Resident Assessment F279, 42 CFR 483.25 Quality of Care F323, 42 CFR 483.75 Administration F490, and F520. The facility was notified on 09/29/11. On 09/05/11, the facility staff observed Resident #2 kissing Resident #6 and took his/her hand and placed it in his/her unzipped pants. On 09/26/11, the facility staff observed Resident #2 with his/her hands under Resident #1's blanket in the living room, with his/her hand moving up and down around the resident's genital area. The facility could provide no evidence of how they provided 1:1 supervision per their policy of the perpetrator and protected residents from potential abuse. While the facility initiated 1:1 after the second incident, they were not supervising the perpetrator during the hours of 10:30PM-6:30AM. The facility failed to follow their Abuse detection and prevention policy related to conducting a thorough investigation, protecting residents from further abuse and reporting the allegation to the state agencies. The facility's failure to provide supervision, report the incidents immediately, and prevent further potential abuse placed residents at risk for serious injury, harm impairment or death. Immediate Jeopardy was identified on 09/29/11, was determined to exist on 09/05/11 and is ongoing based on Resident #2 remained without supervision during the night.	F 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Jeryl L Hozanson	X Administrator	X 10/26/2011

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

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F 000	Continued From page 1 Substandard Quality of Care (SQC) was identified in the areas of 42 CFR 483.13 Resident Behavior and Facility Practices F225, F226, and 42 CFR 483.25 Quality of Care F323. An abbreviated survey KY#16767 was investigated and findings were unsubstantiated.	F 000		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	<u>Corrective Action accomplished for those residents found to have been affected by the deficient practice:</u> 1:1 supervision (a sitter) has been assigned to Resident #2 to ensure that he does not have inappropriate interaction with other residents. He is also being provided with additional activities/1:1 games, which help to keep him preoccupied. This practice will continue until the facility staff is confident that the resident's behavior is such that he won't have inappropriate interaction with other residents. The QA subcommittee, consisting of the Administrator, the VP of Nursing and Client Services, the Director of Social Services, the Assistant Director of Nursing, the Chaplain, and the Medical Director, shall determine whether or not the resident requires continued 1:1 supervision.	10/28/11

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F 225	Continued From page 2 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy regarding "Abuse Detection and Prevention", it was determined the facility failed to complete a thorough investigation regarding allegations of sexual abuse for one (1) of six (6) sampled resident (#2). The facility failed to follow their Abuse Detection and Prevention Policy related to conducting a thorough investigation, protecting residents from further abuse, and reporting the allegation to the State Survey Agency. On 09/05/11, facility staff observed Resident #2 kissing Resident #6 and taking his/her hand and placing it in his/her unzipped pants. On 09/26/11, facility staff observed Resident #2 with his/her hands under Resident #1's blanket in the living room, with his/her hand moving up and down around the resident's genital area. The facility failed to complete a thorough investigation of both incidents, by failing to interview the alleged perpetrator (Resident #2), as well as the other residents on the unit. The facility's failure to provide supervision placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 09/29/11, was determined to exist on 09/05/11 and is	F 225	1:1 supervision will be adjusted based on the findings and the resulting documentation. If the resident's behavior does not change, then 1:1 supervision will continue as other appropriate living options are evaluated. His physician has been consulted, and Res. #2 now has a Climara patch prescribed to help reduce sexual urges. (see attachment). Res. #2's care plan has been modified to reflect his recent behavior, and staff has been made aware of this situation. (attachment) Res. #2's family has been notified of the situation and facility's action, and they are supportive of our interventions. Res. #1 and Res. #6's families have also been notified of the incident and our interventions and they are also supportive. How the facility will identify other residents having the potential to be affected by the same deficient practice: For new residents, a new pre-admission screening tool (see attached) has been developed for the purpose of identifying high-risk behaviors prior to admission. Any current resident involved in an inappropriate interaction will be immediately investigated utilizing the "Checklist for Determining Abuse (willful intent) and Plan of Action." (see attached).	

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F 225	Continued From page 3 ongoing. Substandard Quality of Care (SQC) was identified in the areas of 42 CFR 483.13 Resident Behavior and Facility Practices F225, F226, and 42 CFR 483.25 Quality of Care F323. The findings include: Review of the facility policy "Abuse Detection and Prevention", revised January 2010, regarding...3. Prevention.... j. Resident behaviors which might lead to injury of others will be assessed and addressed through the interdisciplinary team process. Appropriate instruction will be communicated to nurse aides through the assignment sheets so as to prevent resident-to-resident abuse ... 5. Investigation...d. Investigation will include an interview of the alleged victim, alleged perpetrator and all potential witnesses to the allegation...e. Interviews will be conducted by the Vice President of Nursing or her designee with one additional staff person with exceptions authorized by the Vice President of Nursing &Client Services. Document content of interviews....f. Statements may be requested from any and all individuals interviewed....g. The resident's medical record will be reviewed for information applicable to the abuse allegation...h. Information from all sources will be compiled and included in Abuse investigation Reports... i. Upon receiving reports of physical or sexual abuse, the nurse in charge shall be assigned to immediately examine the resident. Findings of the examination must be recorded in the nurse's notes of the resident's medical record and on an Incident/Abuse form. (Note: If sexual abuse is suspected or alleged.	F 225	Measures put in place or systematic changes made to ensure that the deficient practice will not recur: The Abuse Detection and Prevention Policy has been modified to include more exact timelines for reporting and implementation of changes to residents' plan of care. All staff members have been in-serviced regarding the Abuse Detection and Prevention Policy . The Specific Title of the In-service is called, "Abuse Detection and Prevention" and was conducted on September 29 and 30, and October 1, 2011 for all regularly scheduled employees. PRN employees completed their in-service prior to their first shift worked after October 1. The content provided was a thorough review of the facility's Abuse Detection and Prevention Policy. Specifically, the in-service included the following: 1. The staff person informs the team manager of the behavior/issue. 2. The team manager takes appropriate steps to ensure safety of the resident(s) involved. 3. The team manager then begins the assessment process and contacts the on-call management staff for recommendations. 4. Current staff will then be informed of the situation by the team manager and what interventions will be initiated. 5. Resident Care assignment sheets will be updated by the team manager to reflect the new interventions. This information will also be reflected on the resident's plan of care. 6. The team manager will inform on-coming staff of the interventions at change of shift. This will be done at each subsequent change of shift by each team manager.	

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F 225	Continued From page 4 DO NOT bathe the resident or wash the resident's clothing or linen. (Call the police immediately.) Interview with the Social Services Director, on 09/28/11 at 2:30 PM, revealed she was responsible for investigating any allegations of abuse, and reporting these to the required state agencies. The Social Services Director revealed she was primarily responsible for investigations of suspected abuse. A review of the facility's investigation, dated 09/05/11, revealed an incident had occurred between Resident #6 and Resident #2 in the living room of the facility. The facility investigation stated that CNA #6 (who was currently sitting with Resident #6 and an employee of the facility), reported to the 7-3 RN Charge Nurse that Resident #2 had put his/her hand on Resident #6's shoulder, then leaned over and kissed his/her. CNA #6 reportedly tried to separate the two resident's; however, Resident #6 refused to leave the area. At that time both resident's continued watching TV, and approximately 15 minutes later, Resident #2 grabbed Resident #6's hand and put his/her hand down his/her pants. The two were immediately separated and CNA #6 informed 7-3 RN Charge Nurse and the Director of Nursing. Continued review of the investigation revealed Resident #6 had primary diagnoses of Mental Disorder and Anxiety State. The only statement obtained in the investigation was the witness (CNA #6) who reported the incident. Interview with the CNA #6, on 09/29/11 at 4:30 PM, revealed Resident #6 and Resident #2 had been sitting together every day, and Resident #6 considered Resident #2 a boyfriend. The CNA	F 225	7. The Vice President of Nursing & Client Services, or her designee, is responsible for ensuring that this process is followed correctly. Changes to the Plan of Care will be made by the nursing supervisor, when appropriate, at the time of the incident. All nursing supervisors will be educated to this process by October 28, 2011. All policies and procedures related to Abuse Detection and Prevention are reviewed and approved by the Medical Director. The Administrator and VP of Nursing & Client Services are members of the QA sub-committee on Abuse Detection and Prevention and are members of the team responsible for determining interventions for residents with affected behaviors as well as for monitoring at the QA Committee level. The "Audit for Abuse Reports" will be completed by the Assistant Director of Nursing. The audit will be performed monthly on 100% of all "Checklists for Determining Abuse (willful intent) and Plan of Action." This process will continue monthly for at least one year, and then will track its effectiveness concurrently. The Assistant Director has been trained at the recent KAHSA convention by attending the session on "Quality Assessment & Assurance – The Proactive Approach" (see attached). The Medical Director will be involved in monitoring by the following: 1. He will be informed of any resident to resident altercation via his daily report sheet.	

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F 225	Continued From page 5 stated she did not think of this as a problem with abuse. There was no documented evidence of an entry into the medical record that the incident had occurred. Also, there was no evidence the facility conducted an examination or assessment per the facility policy. In addition, there was no evidence the required 5 day follow up investigation, which determines the outcome of the investigation, was not reported to the state agency. Interview with the RN Supervisor on the North Hall, on 09/29/11 at 5:30PM, revealed after the 09/05/11 altercation with Resident #2 and resident #6, the Director of Nursing was notified; however, nothing else was done at that time because Resident #6 had previously been provided a sitter during the day. There was no evidence the victim had been examined after the incident. Continued interview with the Social Services Director, on 09/28/11 at 2:30 PM, revealed there was no specific action taken after the first incident involving Resident #2. The Social Services Director also stated the facility determined this was an isolated incident and did not warrant further action, because everyone felt the two residents were friends. Interview with the Director of Nursing, on 09/28/11 at 6:45 PM, revealed she did not look at the initial incident as a problem with Resident #2 but as a staff issue. The DON stated that since Resident #6 already had scheduled sitters, she felt Resident #6 was protected; however, she did not think about the other residents in the facility, or view this as a new behavior for Resident #2. She stated the resident should have been assessed	F 225	2. A copy of the completed checklist will be placed in his facility mailbox for weekly review. 3. Any changes in policy will be reviewed by the Medical Director prior to implementation. 4. He is available for assisting and planning or providing in-services as needed. 5. Attending Quarterly and or emergency QA meetings. 6. The Medical Director receives copies of all POCs upon completion. The couches in the resident common space will be replaced with recliner chairs to minimize physical interaction between residents.They have been ordered. (see photo of chair and purchase order). How the facility will monitor its performance to ensure that solutions are sustained: The Audit for Alleged Abuse (form/tool) has been implemented and is utilized for all reportable incidents and this information is reported in the monthly Performance Improvement Committee and quarterly Quality Assessment and Assurance committee meetings. (see attached members list) The QA Committee meets for each incident that may be reported so that appropriate action steps can be initiated. A group decision will be made by the QA committee to determine which incidents need to be reported. A "Checklist for Determining Abuse and Plan of Action" is now utilized by the Director of Social	

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F 225	Continued From page 6 initially, and care planned for behaviors, although the resident had not exhibited those behaviors before the 09/05/11 incident. Therefore, the facility could provide no evidence of interventions put in place to prevent further recurrence of potential sexual abuse as the facility did not restrict Resident #2's access to the other residents nor did they increase supervision of Resident #2. Review of a second investigation involving Resident #2, dated 09/26/11, revealed an incident had occurred between Resident #2 and Resident #6 in the patio room of the facility at approximately 11:00 AM. CNA #2 reported to CNA #1 she had observed Resident #2 with his/her hand under a blanket that was covering Resident #1. Resident #1 was sleeping at that time. The report revealed that Resident #2 had his/her hand in the lower region of Resident #1's body, and it appeared the resident was touching his/her genital area. Resident #2 was removed from the area and sitters were arranged to sit with Resident #2 during his/her waking hours. The physician was notified, and a medication was ordered to decrease the resident's sexual desire and control these impulses. Resident #1 was listed on the report as having primary diagnoses of Alzheimer's disease and dementia. While, the facility provided Resident #2 with a sitter from 6:30AM-10:30PM, they were unable to show how the facility supervised the resident from 10:30PM-6:30AM. In addition, the facility did not have evidence that they assessed the resident through the interdisciplinary process by developing a behavior care plan for the resident. Review of Resident #2's clinical record, on	F 225	Services to ensure compliance with the Abuse Detection and Prevention Policy. (See attached). The QA Committee, at its regular meetings, will assess the level of compliance with our Abuse Detection and Prevention Policy. Person(s) responsible to ensure compliance: Administrator and the VP of Nursing and Client Services.	

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F 225	Continued From page 7 09/28/11, revealed no documentation the incident had occurred on 09/26/11. However, review of the nurses notes, on 09/29/11, revealed a late entry nurses note, dated 09/12/11, which stated "resident was sitting in common area on couch with N12-2 (Resident #1), his pants were unzipped with his penis exposed under a pillow. This nurse asked him/her to please put it back in his pants". There was no indication the facility had assessed Resident #2 for the new behaviors. Interview with the RN Supervisor on the North Hall, on 09/29/11 at 5:30PM, revealed when the 09/26/11 incident regarding Resident #2 and Resident #1 was reported to her, she immediately notified the Director of Nursing. There was no evidence the victim had been examined after incident. Further interview with the Social Services Director related to the second incident, on 09/26/11, revealed after the incident, she did not interview the alleged perpetrator, because she did not think he/she would remember. She also stated she did not interview any other residents during the investigation, since sitters were placed with Resident #2 after this incident. Further interview with the DON, on 09/28/11, revealed that appropriate interventions were put into place after the second incident with Resident #2, on 09/26/11. She stated appropriate agencies were notified, family and physician, as well as providing sitters from 6:30 AM-10:30 PM. The DON stated the resident did not usually get up at night and slept through the night. Monitoring of the resident was put into place. However, Resident #2 should have been assessed and	F 225		

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F 225	Continued From page 8 care planned for behaviors after the incident, and a more thorough investigation completed. Observation of Resident #2, on 09/28/11 at 7:15 PM, revealed the resident ambulating about in the hallway independently, with a sitter following behind the resident. An attempt to interview Resident #2 regarding the 09/05/11 incident revealed he/she did not remember the incident. Multiple observations of Resident #2, on 09/28/11 at 2:00 PM, 3:30 PM, 5:20 PM, and 7:15 PM revealed the resident was out of his/her room, ambulating independently in the hallway, or sitting in the patio, or living room. Interview with CNA #1, on 09/29/11 at 2:50 PM, revealed she had not witnessed Resident #2 going into other resident's rooms; however, interview with CNA #2, on 09/28/11 at 5:30 PM, revealed Resident #2 had been observed getting up at night and ambulating to the living room to sit. Therefore, Resident #2 continued to have access to the other residents related to the hours without restriction or supervision by facility staff. Review of the investigation revealed that lack of conducting a thorough investigation and implementing protection of other residents by the facility left the potential for other residents to be sexually assaulted by Resident #2. Interview with the Director of Nursing and Administrator, on 09/29/11 at 1:10PM, revealed the Social Services Director was responsible for conducting the investigation; however, they were responsible for ensuring the investigations were done. Interview with the Social Services Director, on 09/28/11 at 2:30PM, revealed she was	F 225		

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F 225	Continued From page 9 primarily responsible for investigations of abuse and sometimes and Director of Nursing would assist; however, the Social Services Director stated mainly she completed them.	F 225		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy regarding "Abuse Detection and Prevention", it was determined the facility failed to implement their facility policy and procedure related to two allegations of suspected abuse. The facility failed to follow their Abuse, Prevention and Detection Policy by not ensuring all staff was trained on abuse and prevention procedures and failed to ensure the procedure was followed after an allegation was made. The facility failed to identify an allegation as abuse, conduct a thorough investigation and report and protect the residents. The facility was knowledgeable of two incidents of sexual abuse occurring on 09/05/11 and 09/26/11 by a resident perpetrator. The facility staff observed Resident #2, kissing Resident #6 and took his/her hand and placed it in his/her unzipped pants and rubbing Resident #1's genital area. The facility continued to allow Resident #2, the perpetrator, to have access to the other residents after both incidents of sexual abuse. Resident #2, while cognitively impaired, is independent with	F 226	Corrective Action accomplished for those residents found to have been affected by the deficient practice: 1:1 supervision (a sitter) has been assigned to Resident #2 to ensure that he does not have inappropriate interaction with other residents. He is also being provided with additional activities/1:1 games, which help to keep him preoccupied. This practice will continue until the facility staff is confident that the resident's behavior is such that he won't have inappropriate interaction with other residents. The QA subcommittee, consisting of the Administrator, the VP of Nursing and Client Services, the Director of Social Services, the Assistant Director of Nursing, the Chaplain, and the Medical Director, shall determine whether or not the resident requires continued 1:1 supervision. 1:1 supervision will be adjusted based on the findings and the resulting documentation. If the resident's behavior does not change, then 1:1 supervision will continue as other appropriate living options are evaluated. Res. #2's physician has been consulted, and Res. #2 now has a Climara patch prescribed to help reduce sexual urges. (see attachment). Res. #2's care plan has been modified to reflect his recent behavior, and staff has been made aware of this situation. (attachment)	10/28/11

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	185136	A. BUILDING _____ B. WING _____	C 09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

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F 226	Continued From page 10 ambulation. The facility's failure to follow facility policy placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 09/29/11, was determined to exist on 09/05/11 and is ongoing. Substandard Quality of Care (SQC) was identified in the areas of 42 CFR 483.13 Resident Behavior and Facility Practices F225, F226, and 42 CFR 483.25 Quality of Care F323. The findings include: Review of the facility policy regarding "Abuse Detection and Prevention," revised January 2010, under 3. Prevention.... j. Resident behaviors which might lead to injury of others will be assessed and addressed through the interdisciplinary team process. Appropriate instruction will be communicated to nurse aides through the assignment sheets so as to prevent resident-to-resident abuse 5. Investigation: a. investigations of abuse, neglect or misappropriation of resident property shall begin immediately after discovery...d. investigation will include an interview of the alleged victim, alleged perpetrator and all potential witnesses to the allegation... f. Statements will be requested from any and all individuals interviewed; g. the resident's medical record will be reviewed for information applicable to the abuse investigation...h. information from all sources will be compiled and included in Abuse Investigation Reports....i. Findings of the examination must be recorded in the nurse's notes of the resident's medical record...and...6. Protection c. In cases of resident-to-resident abuse, where one resident is at risk for injuring others due to their behavior and	F 226	Res. #2's family has been notified of the situation and facility's action, and they are supportive of our interventions. Res. #1 and Res. #6's families have also been notified of the incident and our interventions and they are also supportive. How the facility will identify other residents having the potential to be affected by the same deficient practice: For new residents, a new pre-admission screening tool (see attached) has been developed for the purpose of identifying high-risk behaviors prior to admission. Any current resident involved in an inappropriate interaction will be immediately investigated utilizing the "Checklist for Determining Abuse (willful intent) and Plan of Action." (see attached). Measures put in place or systematic changes made to ensure that the deficient practice will not recur: The Abuse Detection and Prevention Policy has been modified to include more exact timelines for reporting and implementation of changes to residents' plan of care. All staff members have been in-serviced regarding the Abuse Detection and Prevention Policy . The Specific Title of the In-service is called, "Abuse Detection and Prevention" and was conducted on September 29 and 30, and October 1, 2011 for all regularly scheduled employees. PRN employees completed their in-service prior to their first shift worked after October 1. The content provided was a thorough review of the facility's Abuse	

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F 226	Continued From page 11 their behavior is not readily managed or extinguished, one to one supervision will be provided until a permanent plan to protect all residents has been implemented .... Interview with the Administrator, on 09/29/11 at 2:00 PM, revealed the Social Services Director was responsible for conducting investigations regarding suspected abuse. Record review for Resident #2 revealed the facility admitted the resident on 09/02/10, with diagnoses of Mental Disorder, Depression, and Moderate Dementia. Review of the admission history and physical, dated 10/06/10, revealed the resident had no behaviors prior to admission. Review of the resident's comprehensive significant change, dated 06/09/11 revealed no behaviors had been exhibited, with a Brief Interview for Mental Status (BIMS) score of 4, which determined severe cognitive impairment. 1. Review of the facility's investigation, dated 09/05/11, revealed at approximately 2:00 PM, an inappropriate incident occurred between Resident #6 and Resident #2 in the living room of the facility. The facility investigation stated that CNA #6 (who was currently sitting with Resident #6), reported to the 7-3 RN Charge Nurse that Resident #2 had put his/her hand on Resident #6's shoulder; the resident then leaned over and kissed his/her. CNA #6 reportedly tried to separate the two resident's; however, Resident #6 refused to leave the area. At that time both resident's continued watching TV, and approximately 15 minutes later, Resident #2 grabbed Resident #6's hand and put his/her hand down his/her pants. The two were immediately	F 226	Detection and Prevention Policy. Specifically, the in-service included the following: 1. The staff person informs the team manager of the behavior/issue. 2. The team manager takes appropriate steps to ensure safety of the resident(s) involved. 3. The team manager then begins the assessment process and contacts the on-call management staff for recommendations. 4. Current staff will then be informed of the situation by the team manager and what interventions will be initiated. 5. Resident Care assignment sheets will be updated by the team manager to reflect the new interventions. This information will also be reflected on the resident's plan of care. 6. The team manager will inform on-coming staff of the interventions at change of shift. This will be done at each subsequent change of shift by each team manager. 7. The Vice President of Nursing & Client Services, or her designee, is responsible for ensuring that this process is followed correctly. Changes to the Plan of Care will be made by the nursing supervisor, when appropriate, at the time of the incident. All nursing supervisors will be educated to this process by October 28, 2011. All policies and procedures related to Abuse Detection and Prevention are reviewed and approved by the Medical Director. The Administrator and VP of Nursing & Client Services are members of the QA sub-committee on Abuse Detection and Prevention and are members of the team responsible for	

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F 226	Continued From page 12 separated and CNA #6 informed the 7-3 RN Charge Nurse and the Director of Nursing. Resident #6 had a primary diagnoses of Mental Disorder and Anxiety State, and had been assigned to 1:1 sitters since his/her return from a geriatric psychiatric unit, because of combative behaviors. However, there was no evidence the facility followed their policy relating to Prevention by not thoroughly investigating the cause of the incident, or documentation of the incident in the resident's medical record. Findings revealed there was no evidence of a 5 day follow up investigation reported the the State Agency after the initial incident on 09/05/11. Also, there was no evidence that documentation of the findings of the examination of the victim (Resident #6) was in the medical record. In addition, related to the Protection aspect of the policy, there was no evidence the facility protected all residents in the facility by assessing Resident #2 for behaviors after the incident or provided one to one supervision (sitter) for the resident per facility policy. In addition, there were no interventions put into place to prevent reccurrence of the incident with Resident #2. Interview with the Social Services Director, on 09/2811 at 2:30 PM, revealed the facility felt the two residents were friends and therefore, determined this was an isolated incident, which did not warrant further action. The Social Services Director stated she is responsible for conducting the suspected abuse incidents, as well as reporting. She stated she had failed to complete a follow up investigation (5 day requirement) or send to the state agency. Interview also revealed she was responsible for documenting incidents in the clinical record and	F 226	determining interventions for residents with affected behaviors as well as for monitoring at the QA Committee level. The "Audit for Abuse Reports" will be completed by the Assistant Director of Nursing. The audit will be performed monthly on 100% of all "Checklists for Determining Abuse (willful intent) and Plan of Action." This process will continue monthly for at least one year, and then will track its effectiveness concurrently. The Assistant Director has been trained at the recent KAHSA convention by attending the session on "Quality Assessment & Assurance – The Proactive Approach" (see attached). The Medical Director will be involved in monitoring by the following: 1. He will be informed of any resident to resident altercation via his daily report sheet. 2. A copy of the completed checklist will be placed in his facility mailbox for weekly review. 3. Any changes in policy will be reviewed by the Medical Director prior to implementation. 4. He is available for assisting and planning or providing in-services as needed. 5. Attending Quarterly and or emergency QA meetings. 6. The Medical Director receives copies of all POCs upon completion. The couches in the resident common space will be replaced with chairs. The chairs have been ordered. (See photo of chair and purchase order).	

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F 226	Continued From page 13 should have documented in the nurses notes, or social services notes. Interview with the Director of Nursing (DON), on 09/28/11 at 6:45 PM, revealed CNA #6 should have intervened when the Resident #2 first kissed Resident #6. The DON revealed initially she did not look at the situation as a behavior problem with Resident #2, but as a staff issue. The DON stated that since Resident #6 already had scheduled sitters, she felt the resident was protected. The DON also stated this was a new behavior for Resident #2, and should have been assessed and care planned at that time. The DON revealed that the facility policy required residents with one to one altercations to be assessed for behaviors, placed with supervised sitters, examined, care planned, and monitored. However, the DON stated she was looking at the incident from an entirely different perspective. Interview with the Administrator, on 09/29/11 at 2:00 PM, revealed he thought the policy had been followed regarding the 09/05/11 incident since Resident #6 already had a sitter. However, the Administrator stated he viewed this as an isolated incident, since the behavior had not been observed prior to this incident. The Administrator revealed the policy had not been followed. 2. A second investigation involving Resident #2, dated 09/26/11, revealed an incident had occurred between Resident #2 and Resident #1 in the patio room of the facility at approximately 11:00 AM. CNA #2 reported to CNA #1 that she had observed Resident #2 with his/her hand under a blanket that was covering Resident #1. The report revealed that Resident #2 had his/her	F 226	How the facility will monitor its performance to ensure that solutions are sustained: The Audit for Alleged Abuse (form/tool) has been implemented and is utilized for all reportable incidents and this information is reported in the monthly Performance Improvement Committee and quarterly Quality Assessment and Assurance committee meetings. (see attached members list) The QA Committee meets for each incident that may be reported so that appropriate action steps can be initiated. A group decision will be made by the QA committee to determine which incidents need to be reported. A "Checklist for Determining Abuse and Plan of Action" is now utilized by the Director of Social Services to ensure compliance with the Abuse Detection and Prevention Policy. (See attached). The QA Committee, at its regular meetings, will assess the level of compliance with our Abuse Detection and Prevention Policy. Person(s) responsible to ensure compliance: Administrator and the VP of Nursing and Client Services.	

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F 226	Continued From page 14 hand in the lower region of Resident #1's body and appeared the resident was touching his/her genital area, while the resident was sleeping. While the facility implemented the following interventions. 1) The facility removed Resident #2 from the area, and sitters were arranged to sit with Resident #2 during his/her waking hours from 6:30 AM-10:30 PM. 2) The physician was notified, and a medication was ordered to decrease the resident's sexual desire and control these impulses. There was no evidence the facility provided 1:1 supervision from 10:30 PM until 6:30 AM during the night hours, despite the resident's independence with ambulation. Additionally, interview with CNA #2 revealed that Resident #2 did have a history of getting up at night and ambulating independently to the living room; thus, allowing the resident to have unsupervised access to other residents for 8 hours of the night. Resident #1 was listed on the report as having primary diagnoses of Alzheimer's disease and dementia. Review of the clinical record on 09/28/11 revealed no documentation the incident had occurred. Review also revealed a thorough investigation had not been completed. On 09/28/11 at 2:30 PM, the Social Services Director revealed that she had not conducted a thorough investigation. She stated she had not interviewed the alleged perpetrator (Resident #2) or conducted interviews with the other resident's on the wing, because she did not think they would remember. Continued interview with the DON revealed, after the 09/26/11 incident, the resident was placed on 1:1 supervision on days and evenings; however, the resident would not require a sitter on the night shift because the resident slept all night.	F 226		

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F 226	Continued From page 15 However, interview with CNA #2, on 09/28/11 at 5:30 PM, revealed Resident #2 had been observed getting up at night and ambulating independently to the living room to sit. Observation of Resident #2, on 09/28/11 at 7:15 PM, revealed the resident ambulating about in the hallway independently. An attempt to interview Resident #2, regarding the 09/05/11 incident, revealed he/she did not remember the incident. Multiple observations, on 09/28/11 at 2:00 PM, 3:30 PM, 5:20 PM, and 7:15 PM, revealed the resident was out of his/her room, ambulating in the hallway, or sitting in the patio or living room. Interview with Resident #2, on 09/28/11 at 5:15 PM, revealed the resident was unable to recall any events or details of the incident on 09/05/11. Continued interview with the Administrator also revealed the policy had been revised on January 2010, and contained information on procedures for resident to resident altercations. The Administrator revealed he did not see this as an issue.	F 226		
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	<u>Corrective Action accomplished for those residents found to have been affected by the deficient practice:</u> The Care Plan for Res. #2 has been updated and revised to reflect current care needs (see attached). <u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u> For new residents, a new pre-admission screening tool (see attached) has been developed for the purpose of identifying high-risk behaviors prior to admission.	10/28/11

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F 279	Continued From page 16 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy regarding "Abuse Detection and Prevention", it was determined the facility failed to develop a plan of care for supervision of behaviors for one (1) of six (6) sampled residents (Resident #2). Resident #2, was observed, on 09/05/11, to kiss Resident #6 and to take his/her hand and place it in his/her unzipped pants, with no facility intervention. On 09/26/11, Resident #2 was again observed with his/her hands under Resident #1's blanket in the living room, with his/her hand moving up and down around the resident's genital area. The facility failed to assess and develop a plan of care to address Resident #2's sexual behaviors. This failure placed residents at risk for serious injury, harm impairment or death. Immediate Jeopardy was identified on 09/29/11, was determined to exist on 09/05/11 and is ongoing. The findings include: Review of the facility policy regarding "Abuse Detection and Prevention," revised January 2010,	F 279	Any current resident involved in an inappropriate interaction will be immediately investigated utilizing the "Checklist for Determining Abuse (willful intent) and Plan of Action." (see attached). Immediately following the completion of the Checklist, a care plan will be initiated or interventions updated/revised by the shift supervisor. Quarterly, through the MDS process, the Director of Social Services monitors and assesses for changes in mood and behavior for identifying residents who might who might need special interventions in care planning. <u>Measures put in place or systematic changes made to ensure that the deficient practice will not recur:</u> A "Checklist for Determining Abuse and Plan of Action" is now utilized by the Director of Social Services to ensure compliance with the Abuse Detection and Prevention Policy. (See attached). Changes to the Plan of Care will be made , when appropriate, on the next business day. Changes will be made by an interdisciplinary team member, and changes will be reflected on the Nurse Aide Assignment Sheet timely. All healthcare center team managers are being inserviced on initiating and updating care plans. Dates of the inservice and outlines of materials attached. In-serving will be performed by the Director of RAI and ADON. The Medical Director will be involved in monitoring by the following: 1. He will be informed of any resident to resident altercation via his <u>daily</u> report sheet.	

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F 279	Continued From page 17 under 3. Prevention.... j. Resident behaviors which might lead to injury of others will be assessed and addressed through the interdisciplinary team process. Appropriate instruction will be communicated to nurse aides through the assignment sheets so as to prevent resident-to-resident abuse ... The facility admitted Resident #2 on 09/02/10 with diagnoses of Moderate Dementia, Mental Disorder, Depression, and Diabetes Mellitus. Review of the comprehensive annual assessment on 06/09/11 under the CAA (Care Assessment Area) revealed the facility assessed the resident as having had a cognitive decline and severely impaired cognition and was not considered interviewable. In addition, review of the MDS (Minimum Data Set) Behavior Section E revealed the facility assessed the resident as having no behaviors. Review of the plan of care, dated 02/28/11, revealed no evidence the resident had been assessed or a care plan developed for behaviors. However, a care plan was presented on the evening of 09/28/11 after surveyor intervention. Review of the facility investigation, dated 09/05/11, revealed at approximately 2:00 PM an inappropriate incident occurred between Resident #6 and Resident #2 in the living room of the facility. CNA #6 reported to the 7-3 RN Charge Nurse that Resident #2 had put his/her hand on Resident #6's shoulder and leaned over and kissed his/her. CNA #6 reportedly tried to separate the two resident's, however Resident #6 refused to leave the area. At that time both resident's continued watching TV, and approximately 15 minutes later, Resident #2	F 279	2. A copy of the completed checklist will be placed in his facility mailbox for weekly review. 3. Any changes in policy will be reviewed by the Medical Director prior to implementation. 4. He is available for assisting and planning or providing in-services as needed. 5. Attending Quarterly and or emergency QA meetings. 6. The Medical Director receives copies of all POCs upon completion. How the facility will monitor its performance to ensure that solutions are sustained: The Audit for Alleged Abuse (form/tool) has been implemented and is utilized for all reportable incidents and this information is reported in the monthly Performance Improvement Committee and quarterly Quality Assessment and Assurance committee meetings. (see attached members list) The Vice President for Nursing & Client Services will audit ¼ of the residents per quarter for determining that the care plans have been updated in a timely manner as orders were received. Any issues will be discussed with the responsible supervisory nursing staff as they are discovered. This audit will be performed for one year and then re-evaluated for compliance and effectiveness. The VP of Nursing and Client Services has recently completed the Quality Assessment and Assurance – The Proactive approach training and has 23 years of long-term care experience.	

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F 279	Continued From page 18 grabbed Resident #6's hand and put his/her hand down his/her pants. The two were immediately separated and CNA #6 informed the 7-3 RN Charge Nurse and the Director of Nursing. Review of the facility's investigation revealed no evidence the facility had evaluated the cause of the incident or implemented interventions to address Resident #2's new behavior. Interview with Social Services revealed the IDT was responsible for careplanning the resident's behaviors; however, the team did not follow up on this as they should have. Review of Resident #2's care plan at the time of the initial incident on 09/05/11 revealed..2. Cognitive loss as evidenced by impairment in short term memory related to diagnosis of dementia with possible confounding factors of diabetes and new placement. Furthermore, review of the careplan after the incident revealed there was no documented evidence the facility had developed a care plan for the resident's new behavior or addressed supervision needs to protect other residents. Interview with CNA #6, on 09/29/11 at 4:30 PM, revealed there was no information on the assignment sheet to direct staff in the management of Resident #2's behaviors or the incidents that had taken place. Interview with the Director of Nursing (DON), on 09/28/11 at 6:45 PM, revealed Resident #2 should have been assessed at that time and care planned for behaviors as this was a new behavior for Resident #2.	F 279	Person(s) responsible to ensure compliance: Administrator and the VP of Nursing and Client Services.	

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F 279	Continued From page 19 2. Review of a second incident regarding Resident #2, dated 09/26/11, revealed CNA #2 reported to CNA #1 that she had observed Resident #2 with his/her hand under a blanket that was covering Resident #1, who was sleeping at the time. The report revealed that Resident #2 had his/her hand in the lower region of Resident #1's body and appeared the resident was touching his/her genital area. While the report also revealed the facility removed Resident #2 from the area, arranged sitters to sit with Resident #2 during his/her waking hours, notified the physician, and medication was ordered to decrease the resident's sexual desire and control these impulses; there was no documented evidence that the facility developed a care plan to address the resident's behaviors and need for 1:1 supervision per their policy, until 09/28/11 after surveyor intervention. Observation of Resident #2, on 09/28/11 at 7:15 PM, revealed the resident was ambulating about in the hallway independently. An attempt to interview Resident #2, regarding the 09/05/11 incident, revealed he/she did not remember the incident. Multiple observations, on 09/28/11 at 2:00 PM, 3:30 PM, 5:20 PM, and 7:15 PM, revealed the resident to be out of his room, ambulating in the hallway, or sitting in the patio or living room. Interview with the Director of Nursing, on 09/28/11 at 6:45PM revealed the Interdisciplinary Team (IDT) is responsible for initiating the plan of care, nursing, social services or activities. Interview with the Administrator, on 09/29/11 at	F 279		

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	185136	A. BUILDING _____ B. WING _____	C 09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY MANOR NURSING CENTER	5012 EAST MANSLICK RD LOUISVILLE, KY 40219

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F 279	Continued From page 20 2:00 PM, revealed the care plan should have been developed after the onset of the new behaviors. Refer to F323. S/S " J "	F 279		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy regarding "Abuse Detection and Prevention", it was determined the facility failed to provide adequate supervision for one (1) of six (6) sampled residents (Resident #2). The facility failed to follow their Abuse Policy and Procedure related to protection in cases of resident to resident abuse. On 09/05/11 facility staff reported an allegation of sexual abuse related to Resident #2 kissing and placing Resident #6's hand in his/her unzipped pants. The facility failed to initiate 1:1 supervision of Resident #2 to protect other residents from potential abuse. On 09/26/11, facility staff reported a second allegation of sexual abuse related to Resident #2 touching and rubbing Resident #1's genital area. While the facility initiated 1:1 supervision of Resident #2 from 6:30	F 323	Corrective Action accomplished for those residents found to have been affected by the deficient practice: Res. #2 kissed Res. #6 once on the cheek. When Res. #2 placed Res. #6's hand in the pants of Res. #2, this was a new behavior and unpredictable. The behavior was immediately dealt with by the staff. After the 2nd incident took place, he was immediately placed on 1:1 supervision. Res. # 2 has not been assigned 1:1 supervision between 10:30 pm and 6:30 am, but was monitored at least every two hours, as documented by the shift supervisors, and has always remained in his room the entire time. Currently, we have installed a door alarm (Wireless PIR Alarm System) that notifies the nursing staff if Res. #2 leaves his room at night. All nursing staff, as well as the resident, has been in-serviced regarding this alarm. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this practice. For new residents, a new pre-admission screening tool (see attached) has been developed for the purpose of identifying high-risk behaviors prior to admission. Any current resident involved in an	10/28/11

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F 323	Continued From page 21 AM to 10:30 PM, the facility failed to provide supervision for Resident #2 from 10:30 PM to 6:30 AM. The facility's failure to provide supervision placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 09/29/11, was determined to exist on 09/05/11 and is ongoing. Substandard Quality of Care (SQC) was identified in the areas of 42 CFR 483.13 Resident Behavior and Facility Practices F225, F226, and 42 CFR 483.25 Quality of Care F323. The findings include: Review of the facility policy regarding "Abuse Detection and Prevention", revised January 2010, under... 6. Protection .... c. In cases of resident-to-resident abuse, where one resident is at risk for injuring others due to their behavior and their behavior is not readily managed or extinguished, 1:1 supervision will be provided until a permanent plan to protect all residents has been implemented .... Review of Resident #2's clinical record revealed the facility admitted the resident on 09/02/10, with diagnoses of Mental Disorder, Depression, and Moderate Dementia. Review of the previous admission history and physical, dated 10/06/10, revealed the resident had no behaviors prior to admission. Review of the resident's comprehensive significant change, dated 06/09/11, revealed the facility assessed Resident #2 as having no behaviors exhibited, with a Brief Interview for Mental Status (BIMS) which determined Resident #2 had severe cognitive impairment.	F 323	an inappropriate interaction will be immediately investigated utilizing the "Checklist for Determining Abuse (willful intent) and Plan of Action." (see attached). Specific needs of the residents will be addressed through the care planning process. <u>Measures put in place or systematic changes made to ensure that the deficient practice will not recur:</u> All staff members have been in-serviced regarding the Abuse Detection and Prevention Policy . The following information was provided via in-service to all staff regarding changes in the Abuse Detection and Prevention Policy: If a staff person identifies an inappropriate behavior, the following process is initiated: 1. The staff person informs the team manager of the behavior/issue. 2. The team manager takes appropriate steps to ensure safety of the resident(s) involved. 3. The team manager then begins the assessment process and contacts the on-call management staff for recommendations. 4. Current staff will then be informed of the situation by the team manager and what interventions will be initiated. 5. Resident Care assignment sheets will be updated by the team manager to reflect the new interventions. This information will also be reflected on	

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F 323	Continued From page 22 Review of Resident #2's care plan (updated on 06/22/11) revealed: 2. Cognitive loss as evidenced by impairment in short term memory related to diagnosis of dementia with possible confounding factors of diabetes and new placement. There was no evidence a care plan had been developed for resident behavior. Review of the facility investigation dated, 09/05/11, revealed at approximately 2:00 PM, an inappropriate incident occurred between Resident #6 and Resident #2 in the living room of the facility. The facility investigation stated that CNA #6 (who was currently sitting with Resident #6), reported to the 7-3 RN Charge Nurse that Resident #2 had put his/her hand on Resident #6's shoulder and leaned over and kissed him/her. CNA #6 reportedly tried to separate the two resident's; however, Resident #6 refused to leave the area. At that time both resident's continued watching TV, and approximately 15 minutes later, Resident #2 grabbed Resident #6's hand and put his/her hand down his/her pants. The two were immediately separated and CNA #6 informed 7-3 RN Charge Nurse and the Director of Nursing. Details of the incident were confirmed by the CNA. Interview with the 7-3 RN Charge Nurse, on 09/29/11 at 5:30 PM, revealed CNA #6 reported the incident to her immediately, which was then reported to the Director of Nursing. Continued review of the incident revealed no documented evidence the facility initiated any supervision of Resident #2 to protect residents. Furthermore, there was no documented evidence the facility assessed and evaluated Resident #2 related to the new onset of sexual behaviors.	F 323	the resident's plan of care. This plan of care will be updated within 24 hours from the decision on new interventions. 6. The team manager will inform on-coming staff of the interventions at change of shift. This will be done at each subsequent change of shift by each team manager. 7. The Vice President of Nursing & Client Services, or her designee, is responsible for ensuring that this process is followed correctly. Mandatory Resident Rights/Abuse/Advance Directives In-service is being conducted between October 26 and November 1, 2011 by the Director of Social Services and the Staff Development Coordinator. A "Checklist for Determining Abuse and Plan of Action" is now utilized by the Director of Social Services to ensure compliance with the Abuse Detection and Prevention Policy. (See attached). The checklist includes actions to ensure adequate supervision of all residents involved. The couches in the resident common space will be replaced with recliner chairs to minimize physical interaction between residents. The order has been placed (see photo of chair and purchase order). All regularly-scheduled facility care-giving staff was in-serviced regarding the Abuse Prevention and Detection policy between 09/29/11 and 01/01/11.	

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F 323	Continued From page 23 Review of the clinical record and careplan after the incident revealed no new interventions were implemented to address staff supervision of Resident #2 or the sexual behaviors. There was no evidence a care plan had been developed for the resident's new behaviors. Interview with CNA #6, on 09/29/11 at 4:30 PM, revealed Resident #2 had never exhibited this type of behavior before the 09/05/11 incident. Interview with the Social Services Director, on 09/28/11 at 2:30 PM, revealed there was no specific actions taken after the incident. The Social Services Director also stated the facility determined this was an isolated incident and did not warrant further action, because everyone felt the two residents were friends. Interview with the Director of Nursing (DON), on 09/28/11 at 6:45 PM, revealed CNA #6 should have intervened when the Resident #2 first kissed Resident #6. The DON revealed she did not look at the situation as a problem with Resident #2, but as a staff issue. The DON stated that since Resident #6 already had scheduled sitters, she felt Resident #6 was protected. The DON also stated this was a new behavior for Resident #2, and should have been assessed at that time and care planned for behaviors. In addition, further review of the nurses notes revealed a late entry nurses note, dated 09/12/11 at 3:20 PM, which revealed: "Resident was sitting in common area on couch with N12-2, (Resident #1), his/her pants were unzipped with his penis exposed under a pillow". There was no evidence	F 323	No PRN staff was allowed to work until in-serviced by the D.O.N., the Assistant D.O.N, or the Staff Development Coordinator. The Medical Director will be involved in monitoring by the following: 1. He will be informed of any resident to resident altercation via his daily report sheet. 2. A copy of the completed checklist will be placed in his facility mailbox for weekly review. 3. Any changes in policy will be reviewed by the Medical Director prior to implementation. 4. He is available for assisting and planning or providing in-services as needed. 5. Attending Quarterly and or emergency QA meetings. 6. The Medical Director receives copies of all POCs upon completion. How the facility will monitor its performance to ensure that solutions are sustained: The Audit for Alleged Abuse (form/tool) has been implemented and is utilized for all reportable incidents and this information is reported in the monthly Performance Improvement Committee and quarterly Quality Assessment and Assurance committee meetings. (see attached members list). The tool is completed monthly by the ADON and reported to Administration at the monthly meetings. The Medical Director receives monthly reports at the QA meetings. All incidents are audited (100%) and this process will be done monthly for one year, and then evaluated for compliance and effectiveness.	

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F 323	Continued From page 24 the facility assessed Resident #2 for any new behaviors. Review of a second investigative report, dated 09/26/11, revealed an incident had occurred between Resident #2 and Resident #1 in the patio room of the facility at approximately 11:00 AM. CNA #2 reported to CNA #1 that she had observed Resident #2 with his/her hand under a blanket that was covering Resident #1, who was sleeping at the time. The report detailed that Resident #2 had his/her hand in the lower region of Resident #1's body and it appeared the resident was touching his/her genital area. The report also revealed the facility removed Resident #2 from the area, and established 1:1 supervision form 6:30 AM to 10:30 PM. The facility notified the physician and received an order for medication to address th resident's sexual desires. The clinical record, on 09/28/11, revealed no documentation the incident had occurred. Interview with CNA #2, on 09/28/11 at 5:30 PM, confirmed the information in the investigative report. Interview with CNA #1, on 09/28/11 at 2:50 PM, revealed she was coming from the West Hall, and observed Resident #2 sitting next to Resident #1 with his/her hand under Resident #1's blanket, and appeared to have an up and down motion, using his/her hand. Interview also revealed the residents were separated, and immediately reported to the Director of Nursing, at which time Resident #2 was assigned sitters from 6:30 AM-10:30 PM, during waking hours. CNA #1 stated she had not witnessed the resident going into other resident's rooms since the first incident on 09/05/11; however, interview with CNA #2 revealed Resident #2 had been	F 323	Person(s) responsible to ensure compliance: Administrator and the VP of Nursing and Client Services.	

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F 323	Continued From page 25 observed getting up at night and going to the living room to sit. Interview with Social Services Director, on 09/28/11 at 2:30 PM, revealed the facility did not develop a care plan for behaviors after the incident. Interview with the Director of Nursing on 09/28/11 at 6:45PM revealed Resident #2 had never exhibited these behaviors before; however, stated that after the first incident, the resident should have been assessed and care planned for behaviors. The DON stated that according to their facility policy, the resident should have been supervised after the sexual encounter with Resident's #6. Observation of Resident #2, on 09/28/11 at 7:15 PM, revealed the resident was ambulating about in the hallway independently. An attempt to interview Resident #2 regarding the 09/05/11 incident revealed he/she did not remember the incident. Multiple observations, on 09/28/11 at 2:00 PM, 3:30 PM, 5:20 PM, and 7:15 PM revealed the resident was out of his/her room, ambulating in the hallway, or sitting in the patio, or living room. Interview with the Director of Nursing, on 09/28/11 at 6:45 PM, revealed after the incident, the physician and responsible parties were notified, and the resident was placed on 1:1 sitter supervision. The DON also stated the physician ordered medication to decrease sexual impulses, and a psychological consult was ordered. Interview with the Administrator, on 09/29/11 at	F 323		

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F 323	Continued From page 26 2:00 PM, revealed he thought the incidents were addressed by providing the residents with sitters, and felt this incident was isolated since the behavior had not been observed prior to the initial incident. The Administrator also revealed that he reviews investigations at times with the Director of Nursing and Social Services Director; however, he did not review the 09/05/11 incident and discussed the 09/26/11 incident in the morning meeting. The second incident was identified as an abuse allegation; however, he did not ensure the abuse policy was followed by investigating, protecting, reporting, and educating the staff. While the Administrator felt providing sitters for the resident addressed the incident the facility did not ensure the perpetrator, Resident #2, was supervised 1:1 by facility staff 24 hours a day since 09/05/11 and had not developed a permanent plan as specified per their policy. This failure prevented the facility from protecting it's residents from further abuse.	F 323		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility's administration failed to administer effectively to ensure adequate supervision and protection of all	F 490	Corrective Action accomplished for those residents found to have been affected by the deficient practice: The Administrative staff will be personally involved in the safety and well-being of all residents through close, effective administration of the Abuse Detection and Prevention Policy, through the QA process to determine the individual needs of any identified resident, and the decision process for reporting incidents and the allocation of facility resources. The administrative staff includes, the Administrator, The VP of Nursing & Client Services, the Director of Social Services, and the Director of Pastoral Care. Through committee and sub-committee involvement, daily walking rounds, staff	10/28/11

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F 490	Continued From page 27 residents residing in the facility. In addition, the administration failed to ensure thorough investigations were completed according to the facility policies and procedures for resident to resident altercations. The facility also failed to provide training to staff after two incidents of suspected abuse. This affected one (1) of six (6) sampled residents (Resident #2). On 09/05/11, facility staff observed Resident #2 kissing Resident #6 and took his/her hand and placed it in his/her unzipped pants. On 09/26/11, the facility staff again observed Resident #2 with his/her hands under Resident #1's blanket in the living room, with his/her hand moving up and down around the resident's genital area. The facility's failure to administer effectively and efficiently to provide supervision placed residents at risk for serious injury, harm impairment or death. Immediate Jeopardy was identified on 09/29/11, was determined to exist on 09/05/11 and is ongoing. The findings include: Review of two facility investigations, dated 09/05/11 and 09/26/11, revealed sexual altercations had occurred regarding Resident #2; however, the facility did not to address the first incident or implement interventions regarding Resident #2's behaviors or assess and care plan the resident for behaviors. In addition, the facility did not to supervise Resident #2 allowing access to other residents. (Refer to F279 "J", F323 "J") Further review of the facility investigation revealed there was no evidence the facility had completed a thorough investigation by evaluating the cause of the incident, nor assessing and	F 490	meetings and discussions, and via policy direction, the administration is continually involved in this process. Resident #2's safety and well-being is ensured via 1:1 supervision during waking hours, electronic supervision at night, and staff are providing Res. #2 with stimulating activities, as he wishes, during his waking hours. <u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u> All residents have the potential to be affected by this practice. For new residents, a new pre-admission screening tool (see attached) has been developed for the purpose of identifying high-risk behaviors prior to admission. Any current resident involved in an inappropriate interaction will be immediately investigated utilizing the "Checklist for Determining Abuse (willful intent) and Plan of Action." (see attached). Specific needs of the residents will be addressed through the care planning process. <u>Measures put in place or systematic changes made to ensure that the deficient practice will not recur:</u> All staff members have been in-serviced regarding the Abuse Detection and Prevention Policy.	

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F 490	Continued From page 28 putting interventions into place to prevent reoccurrence of the incident. Interview with the Social Services Director, on 09/28/11 at 2:30PM revealed the IDT (Interdisciplinary Team) was responsible for careplanning the resident's behaviors; however, the team did not follow up on this as they should have. (Refer to F225 "J", F225 "J") Interview with the Social Services Director, on 09/28/11 at 2:30 PM, revealed she was responsible for conducting the investigation and reporting the alleged abuse She was responsible for reporting to the State agencies; however, she revealed there were no interviews with residents involved nor was it reported to the state agencies. In addition, the investigation did not include interviews with other residents in the facility. Observation of Resident #2, on 09/28/11 at 7:15 PM, revealed the resident ambulating independently about in the hallway. Multiple observations, on 09/28/11 at 2:00 PM, 3:30 PM, 5:20 PM, and 7:15 PM revealed the resident out of his/her room, independently ambulating in the hallway, or sitting in the patio or living room with a sitter at his/her side. Interview with the Staff Development Coordinator (SDC), on 09/29/11 at 4:30PM, revealed she was responsible for the training in the facility. The SDC revealed Abuse In-services are completed annually and upon hire. She also stated the last facility wide Abuse in-service was in March 2010 and was not scheduled again until November 2011.	F 490	The following information was provided via in-service to all staff regarding changes in the Abuse Detection and Prevention Policy: If a staff person identifies an inappropriate behavior, the following process is initiated: 1. The staff person informs the team manager of the behavior/issue. 2. The team manager takes appropriate steps to ensure safety of the resident(s) involved. 3. The team manager then begins the assessment process and contacts the on-call management staff for recommendations. 4. Current staff will then be informed of the situation by the team manager and what interventions will be initiated. 5. Resident Care assignment sheets will be updated by the team manager to reflect the new interventions. This information will also be reflected on the resident's plan of care. This plan of care will be updated within 24 hours from the decision on new interventions. 6. The team manager will inform on-coming staff of the interventions at change of shift. This will be done at each subsequent change of shift by each team manager. 7. The Vice President of Nursing & Client Services, or her designee, is responsible for ensuring that this process is followed correctly. Annual Mandatory Resident Rights/Abuse/Advance Directives In-service is being conducted between October 26 and	

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F 490	Continued From page 29 Interview with the Assistant Director of Nursing, on 09/28/11 at 7:00PM, revealed there was no formal or documented training involved with staff since the incident. The ADON stated the facility had not completed training because Resident #2 now had a sitter from 6:30AM-10:30PM, and did not feel necessary. Interview with the Director of Nursing, on 09/28/11 at 6:45 PM, revealed she did not look at the initial incident as a problem with Resident #2, but as a staff issue. The DON also stated this was a new behavior for the resident, and should have been assessed and care planned at that time for behaviors. Interview with the Administrator, on 09/29/11 at 2:00 PM, revealed he thought the incidents were addressed by providing the resident's with sitters. The Administrator stated he felt the first incident was isolated since the behavior had not been observed prior to the initial incident. The Administrator stated the Staff Development Coordinator had been hired a few months ago; however, there had been no training for staff since the two incidents. The Administrator stated he was not routinely involved in the facility's investigations. Although he reviewed investigations at times with the Director of Nursing and Social Services Director, he had not reviewed these incidents. Thus, there was no evidence the facility Administration took action and oversight to ensure Policy and Procedure protection of residents from abuse. (Refer to F520 "J")	F 490	November 1, 2011 by the Director of Social Services and the Staff Development Coordinator. A "Checklist for Determining Abuse and Plan of Action" is now utilized by the Director of Social Services and/or the VP of Nursing and Client Services to ensure compliance with the Abuse Detection and Prevention Policy. (See attached). The checklist includes actions to ensure adequate supervision of all residents involved. The couches in the resident common space will be replaced with recliner chairs to minimize physical interaction between residents. The order has been placed (see photo of chair and purchase order). All regularly-scheduled facility care-giving staff was in-serviced regarding the Abuse Prevention and Detection policy between 09/29/11 and 01/01/11. No PRN staff was allowed to work until in-serviced by the D.O.N., the Assistant D.O.N, or the Staff Development Coordinator. The Medical Director will be involved in monitoring by the following: 1. He will be informed of any resident to resident altercation via his daily report sheet. 2. A copy of the completed checklist will be placed in his facility mailbox for weekly review. 3. Any changes in policy will be reviewed by the Medical Director prior to implementation. 4. He is available for assisting and	
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS			

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	185136	A. BUILDING _____ B. WING _____	C 09/29/2011

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F 520	Continued From page 30 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility plan of correction for immediate Jeopardies identified on 10/20/10 and 12/21/10 in the area of F323 (Supervision), it was determined the facility failed to maintain an effective quality assurance program (QA) to identify quality concerns. Review of the 10/20/10 plan of correction, it was determined the facility failed to ensure that staff	F 490 Cont.	5. planning or providing in-services as needed. 6. Attending Quarterly and or emergency QA meetings. 7. The Medical Director receives copies of all POCs upon completion. How the facility will monitor its performance to ensure that solutions are sustained: The Audit for Alleged Abuse (form/tool) has been implemented and is utilized for all reportable incidents and this information is reported in the monthly Performance Improvement Committee and quarterly Quality Assessment and Assurance Committee meetings. (see attached members list) Person(s) responsible to ensure compliance: Administrator and the VP of Nursing and Client Services. Corrective Action accomplished for those residents found to have been affected by the deficient practice: The Facility has modified the QA process to be involved on an on-call basis as well as scheduled meetings. The QA sub-committee will be involved whenever an incident is elevated to a level that is potentially reportable. The QA sub-committee comprised of at least three members determines whether or not an incident is reportable. The medical director will receive a written report (completed copy) of all meetings of the sub-committee.	
		F 520		10/28/11

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F 520	Continued From page 31 were trained on the appropriate use of assistive devices, per manufacturer's recommendations, to prevent accidents. The facility's failure to ensure adequate training of their staff resulted in an avoidable accident for Resident #1. On 10/07/10, staff transported Resident #1 using a Rollator walker, when the Rollator walker flipped over causing the resident to sustain a head injury. Resident #1 required hospitalization with diagnoses of coma secondary to intracranial hemorrhage (bleeding within the skull). The facility's failure to ensure staff were appropriately trained regarding the safe use of assistive devices placed residents at risk for serious injury, harm, impairment or death. Review of the plan of correction for the 12/21/10 determined the facility failed to provide quality care, treatment, and supervision of residents identified by the facility as at risk for elopement. The facility failed to ensure policies and procedures were developed which detailed staff responsibilities, and failed to ensure staff was trained related to the policies and procedures. The facility failed to ensure alarms were functioning properly and audible to alert staff when the emergency exit door was opened at the end of the corridor/tunnel. On 12/12/10, Resident #4 and Resident #5 who the facility identified as at risk for elopement exited the locked unit and the facility without staff knowledge or supervision. Resident #4 and Resident #5 were found standing outside the facility. Immediate Jeopardy was found to exist on 12/17/10 and the facility was notified of Immediate Jeopardy and Substandard Quality of Care on 12/17/10. The facility failed to investigate and develop plans	F 520	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the ability to be affected by the deficient practice. Measures put in place or systematic changes made to ensure that the deficient practice will not recur: Implementation, education, and close administrative involvement in the facility's Abuse Detection and Prevention Policy will ensure that the deficient practice will not recur. Al QA Committee members will receive education by October 28, 2011, by Upstairs Solutions, titled "Quality Assessment and Assurance – The Proactive Approach" (course outline attached), and will receive educational updates annually. How the facility will monitor its performance to ensure that solutions are sustained: The Audit for Alleged Abuse (form/tool) has been implemented and is utilized for all reportable incidents and this information is reported in the monthly Performance Improvement Committee and quarterly Quality Assessment and Assurance committee meetings. (see attached members list) The tool is completed monthly by the ADON and reported to Administration at the monthly meetings. The Medical Director receives monthly reports at the QA meetings. All incidents are audited (100%) and this process will be done monthly for one year, and then evaluated for compliance and effectiveness.	

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F 520	Continued From page 32 of action in response to identified problems. Members of the QA committee were aware their system to identify allegations of suspected abuse had failed. However, all aspects of the facility's system to recognize new behavior for residents were not investigated, thus preventing the facility from implementing the needed plans of action to correct the deficient area. This failure affected all residents of the facility relative to the system for ensuring that residents are assessed, supervised, and a plan of care developed after resident to resident altercations. In addition, the facility did not perform a quality assessment and investigation relative to the two separate incidents of resident to resident altercations, on 09/05/11 and 09/26/11. The facility also failed to provide re-training after the two incidents of suspected sexual abuse were reported. Additionally, the facility failed to maintain compliance related to supervision to prevent accidents after having two previous Immediate Jeopardy citations since 10/2010. The failure of the facility to conduct thorough quality assessments ensuring adequate supervision and protection of all residents were received placed the residents in Immediate Jeopardy. The Immediate Jeopardy was identified on 09/29/11 and determined to exist on 09/05/11 and is ongoing in the areas of: (483.13 F225 "J"; 483.13 F226 "J"; 483.20 F279 " J"; 483.25 F323 "J"; 483.75 F490 "J"; and 483.75 F520 "J". Substandard Quality of Care (SQC) was determined to exist in the areas of 483.13 Resident Behavior and Facility Practices (F225	F 520	The Vice President for Nursing & Client Services will audit ¼ of the residents per quarter for determining that the care plans have been updated in a timely manner as orders were received. Any issues will be discussed with the responsible supervisory nursing staff as they are discovered. This audit will be performed for one year and then re-evaluated for compliance and effectiveness. The VP of Nursing and Client Services has recently completed the Quality Assessment and Assurance – The Proactive approach training and has 23 years of long-term care experience. Any negative findings in any audits presented to the QA Committee, will be addressed via "Root Cause Analysis", focused rounds, and a designed plan of action to correct the negative situation. The Medical Director will be involved in monitoring by the following: 1. He will be informed of any resident to resident altercation via his daily report sheet. 2. A copy of the completed checklist will be placed in his facility mailbox for weekly review. 3. Any changes in policy will be reviewed by the Medical Director prior to implementation. 4. He is available for assisting and planning or providing in-services as needed. 5. Attending Quarterly and or emergency QA meetings. 6. The Medical Director receives copies of all POCs upon completion.	

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F 520	Continued From page 33 "J") 483.13 Resident Behavior and Facility Practices (F226 "J") and 483.25 Quality of Care (F323 "J"). The facility will also be cited under Quality Assurance for previous non-compliance, based on previous Immediate Jeopardy identified in areas of 483.25 F323 S/S "K", 483.75 F490 S/S "K" on 12/14/10, and 483.25 F323 S/S "J" identified on 10/20/10. The findings include: Review of the 12/20/10 statement of deficiencies revealed Immediate Jeopardy was identified in F323. Review of the facility's plan of correction revealed the facility's Administrator would participate in policy and procedure revision and attend regularly scheduled meetings of the Quality Assurance Committee. Interviews and record review revealed Resident #2 did not receive an assessment for behaviors after two incidents of suspected sexual abuse occurred, on 09/05/11 and 09/26/11. (Refer to F323). Interview with the Administrator, on 09/29/11 at 1:20 PM, revealed the last Quality Assurance Meeting (QA) had been held, on 07/21/11, with the Medical Director in attendance. The Administrator revealed no behaviors had been discussed this year in their Quality Assurance meeting, nor had the Abuse Policy been discussed. The Administrator stated the QA meeting was held monthly with facility staff, then, a more formal QA meeting is held quarterly, at which time the Medical Director attends.	F 520	Person(s) responsible to ensure compliance: Administrator and the VP of Nursing and Client Services.	

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F 520	Continued From page 34 In addition, interview with multiple members of the QA committee, on 09/29/11, with the Administrator and Director of Nursing at 3:45 PM, Assistant Director of Nursing at 3:00 PM, Staff Development Coordinator at 4:30 PM, and the Medical Director (was called at 5:30 PM-did not return call), revealed the facility had not taken steps to investigate the system of how residents were assessed and supervised after incidents of suspected abuse. Neither the Administrator or DON had identified, until surveyor intervention, that Resident #2's behaviors had not been assessed and care planned, and the incidents had not been thoroughly investigated. (refer to F323) Members of the QA committee, including the Administrator and DON, were unaware until surveyor intervention, that Resident #2 had not been assessed for the new behavior, or did not realize the facility policy was not followed regarding "Abuse Detection and Prevention". Interview with the Administrator, on 09/29/11 at 2:00 PM, revealed he thought the incidents with Resident #2 had been addressed by providing sitters, and felt this incident was isolated since the behavior had not been observed prior to the initial incident. The Administrator also revealed he reviews investigations at times with the Director of Nursing and Social Services Director; however, interview revealed that both the Administrator and Director of Nursing were not aware the investigations were incomplete, the behaviors had not been assessed and care planned and protection of residents during the investigation had not been implemented through 1:1 supervision per the policy. Furthermore, the facility was unable to provide evidence that their	F 520		

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F 520	Continued From page 35 QA program had identified quality concerns related to supervision to prevent accidents and had reviewed their systems to ensure continued compliance after repeated Immediate Jeopardy citations related to supervision in 2010.	F 520		