

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

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JUN 18 2014

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE COMPLETION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/07/2014
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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY #10 BYPASS MONTICELLO, KY 42633
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY21601, KY21579) was initiated on 04/23/14 and concluded on 05/07/14. KY21601 was found to be unsubstantiated with no deficient practice identified. KY21579 was found to be substantiated and Immediate Jeopardy was identified on 04/24/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 483.75 Administration (F490) at a scope and severity of "J," with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226), which was determined to exist on 01/18/14. The facility was notified of the Immediate Jeopardy on 04/24/14. On 01/18/14, Resident #7 complained to Certified Nurse Aide (CNA) #7 and CNA #8 during the incontinence care that CNA #8 had hurt him/her. CNA #7 and CNA #8 notified the primary nurse, Licensed Practical Nurse (LPN) #2, of the resident's complaint. However, LPN #2 failed to take any action to investigate, report, or protect residents from further abuse. On 01/22/14, Registered Nurse (RN) #2 notified the Director of Nursing (DON) of Resident #7's allegation of abuse related to CNA #8; however, the DON also failed to initiate an investigation, report the allegation as required, or protect residents from further potential abuse during the facility's investigation. Additionally, deficient practice was identified at F166 at a scope and severity of "D."</p> <p>A partial extended survey was conducted on 05/06-07/14. An acceptable Allegation of Compliance was received on 05/05/14 which alleged removal of the Immediate Jeopardy on 05/03/14. The State Survey Agency determined the Immediate Jeopardy was removed on</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *adm* DATE *6/18/2014*

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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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
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F 000	Continued From page 1 05/03/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000			
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166	Please See Attachment F166		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's grievance policy and procedure it was determined the facility failed to ensure resident grievances were promptly resolved. Review of Resident Council meeting minutes for February, March, and April 2014 revealed residents repeatedly complained about staff failing to answer call lights in a timely manner. However, the facility failed to make prompt efforts to resolve the resident complaints and/or to keep the residents apprised of its progress toward a resolution. The findings include: Review of the facility's policy and procedure, "Resident Grievance Policies and Procedures," undated, revealed grievances could be presented orally or in writing, and could be related to treatment and services provided. The policy indicated that grievances would be directed to the				

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F 166	<p>Continued From page 2</p> <p>Charge Nurse, and if the grievance could not be resolved by the Charge Nurse it would be directed to the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). At that time, the grievance would be discussed and investigated. According to the policy, if a resolution was not reached, a group meeting would be arranged with all parties involved until a resolution was reached. The policy revealed resolutions would be documented and updates on the progress would be reported to involved residents.</p> <p>Review of Resident Council Meeting minutes dated 02/17/14, revealed residents in attendance reported during the month of January 2014 that staff failed to answer call lights in a timely manner. According to the report, the residents had also reported their concerns the previous month (January 2014) and reported they had not observed any improvement approximately one month later.</p> <p>Review of Resident Council Meeting minutes dated 03/24/14, revealed the residents reported staff continued to be slow in answering call lights and that it "is no different, the aides are still slow."</p> <p>Review of Resident Council Meeting minutes dated 04/21/14, revealed the residents continued to complain that staff was slow to answer call lights, and emphasized the problem was worse on Saturdays and Sundays.</p> <p>Review of the medical record revealed facility staff had assessed Resident #6 to have a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Interview with Resident #6 on 05/07/14, at</p>	F 166			

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F 166	<p>Continued From page 3</p> <p>9:55 AM revealed staff was slow to answer call lights "at times" and they were "especially" slow on weekends.</p> <p>Review of the medical record revealed facility staff had assessed Resident #5 to have a BIMS score of 15, which indicated the resident's cognition was intact. Interview with Resident #5 on 04/23/14 at 10:15 AM revealed the problem related to staff failure to answer call lights in a timely manner had been discussed in several council meetings, but he/she was unaware if the facility had initiated action to reconcile the complaints.</p> <p>Review of the medical record revealed facility staff had assessed Resident #4 to have a BIMS score of 13, which revealed the resident's cognition was intact. Interview with Resident #4 revealed he/she had voiced complaints in the monthly resident council meetings that staff was slow "at times" to answer call lights.</p> <p>Interview with the Social Services Director/Activity Director (SSD/AD), on 04/25/14 at 10:10 AM revealed she conducted the Resident Council Meetings, recorded the minutes of the meeting, and provided a copy to the Administrator. The SSD/AD stated the residents had complained for several months that staff was "slow" to answer lights, but she was unaware of any action the facility had taken to monitor or resolve the complaint. The SSD/AD stated it was not her responsibility to conduct audits related to staff training and/or the timeliness of staff response to call lights. The SSD/AD also stated complaints received during one month's Resident Council Meetings were discussed with the residents at the following month's meeting. However, the</p>	F 186			

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F 166	Continued From page 4 SSD/AD was unable to provide further information related to how the facility had worked to resolve the residents' complaints. Interview on 04/24/14 at 5:05 PM and on 04/25/14 at 10:20 AM with the DON revealed she was aware that residents had voiced complaints that staff failed to answer call lights in a timely manner. The DON stated she had spoken with staff regarding answering call lights timely but had not provided an in-service and/or training for staff related to answering call lights. The DON stated the facility did not record resident grievances and did not track or trend resident grievances. According to the DON, the facility did not have a system in place to inform residents of facility actions and/or progress toward resolutions to the residents' complaints. Interview with the Administrator/Co-Owner was conducted on 04/25/14, at 10:55 AM; however, the Administrator was ill and the interview was not completed. The Administrator provided no information related to the facility's process for resident grievances.	F 166			
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	F 225	Please See Attachment F225		

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F 225	<p>Continued From page 5</p> <p>other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Incident Report, and review of the facility's policy and procedures, it was determined the facility failed to ensure allegations of resident abuse and misappropriation of resident property were reported immediately to the State Survey Agency and other officials in accordance with state law for three (3) of four (4) sampled residents (Residents #7, #5, and #6). The facility failed to ensure all allegations were investigated and failed to ensure</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>residents were protected from further potential abuse during the facility's investigation.</p> <p>Interviews and record review revealed Resident #7 informed Certified Nurse Aides (CNAs) #7 and #8 that CNA #8 had hurt him/her when they provided incontinence care to him/her. CNAs #7 and #8 informed Licensed Practical Nurse (LPN) #2 of the resident's complaint when they (CNAs #7 and #8) left the resident's room. However, LPN #2 failed to immediately report the allegation to the Administrator and State agencies, failed to initiate an investigation of the allegation, and failed to ensure residents were protected from further abuse during the course of the investigation. Further review revealed Resident #7, LPN #2, CNA #8, and CNA #7 could not recall the exact date of the incident. Interview on 04/24/14 at 5:50 PM with Registered Nurse (RN) #2 revealed she interviewed Resident #7 on 01/22/14 about an incident Resident #7 had reported to RN #3.</p> <p>Interviews and review of the Incident Report revealed on 01/22/14, the resident informed RN #2 that four days prior (01/18/14) Certified Nurse Aide (CNA) #8 hurt him/her when he provided incontinence care to the resident. Interview with RN #2 revealed she reported the abuse allegation to the Director of Nursing (DON). Interview with the DON on 04/24/14 at 5:05 PM revealed that due to witnesses being present who denied that CNA #8 had intentionally hurt Resident #7 (on 01/18/14), she advised staff that CNA #8 could continue to provide care to other facility residents, but CNA #8 would not be allowed to provide direct care to Resident #7. The DON stated she did not report the allegation to the Administrator of the facility and State agencies as required. In</p>	F 225			

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F 225	<p>Continued From page 7</p> <p>addition, the facility failed to conduct interviews with additional staff and residents during the course of the facility's investigation, and failed to take action to protect residents from further abuse/potential abuse until 04/24/14 (95 days after the allegation of abuse) when the facility removed CNA #8 from direct patient care in the facility.</p> <p>Additionally, around 04/18/14 (exact date unknown) Resident #5 reported to facility staff that six dollars (\$6.00) and a pair of pants were missing from his/her room; and on 02/04/14, Resident #6 reported that thirty-six dollars (\$36.00) was missing from his/her room. Although the facility reimbursed Residents #5 and #6 for the reported missing monies, the facility failed to conduct an investigation or report the possible misappropriation of resident property to the appropriate State agencies as required.</p> <p>The facility's failure to immediately report all allegations of abuse, failure to protect residents during the course of an investigation of abuse, and failure to investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 01/18/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 483.75 Administration (F490) with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). The facility was notified of the Immediate Jeopardy on 04/24/14.</p> <p>A partial extended survey was conducted on 05/06-07/14. An acceptable Allegation of Compliance was received on 05/05/14 which</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>alleged removal of the Immediate Jeopardy on 05/03/14. The State Agency determined the Immediate Jeopardy was removed on 05/03/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Resident Abuse," (not dated) revealed the facility would immediately report, and thoroughly investigate, all allegations of mistreatment, neglect, abuse, and misappropriation of resident property. Further review revealed all alleged incidents involving mistreatment, abuse, or misappropriation of resident property were to be reported immediately to the Administrator. In addition, the policy revealed the Administrator, or his/her designee, would immediately notify the appropriate State agencies of the allegation. The policy also revealed the facility would prevent further potential abuse during the course of the investigation, including the removal of alleged staff from the care of all residents.</p> <p>1. Review of Resident #7's medical record revealed the facility admitted the resident on 12/19/12 with diagnoses that included Chronic Airway Obstruction, Spinal Stenosis, Dementia, Anxiety, Confessional Arousals, Hallucinations, and Contracture of Lower Leg Joint. Review of Resident #7's Minimum Data Set (MDS) dated 02/17/14, revealed the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of 12, which indicated the resident's</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>cognition was moderately impaired.</p> <p>Review of a "Complaint of Abuse/Neglect" form, not dated and not signed, revealed on 01/22/14, Resident #7 reported to Registered Nurse (RN) #3 that CNA #8 had hurt him/her while providing incontinence care "four" days ago. Further review of the form revealed RN #3 informed RN #2 of the resident's allegations, and RN #2 completed an incident report and interviewed Resident #7. Continued review of the report revealed Resident #7 informed RN #2 that CNA #8 was "always rough" with him/her. The resident further stated he/she "told" the CNA he was hurting him/her and he started "laughing" and said "you are just being a limid [boy/girl]."</p> <p>Interview with Resident #7 on 04/24/14 at 10:30 AM revealed Certified Nurse Aide (CNA) #8 "hurt me." Resident #7 was unable to recall the exact date of the incident but stated CNA #8 intentionally caused pain by forcibly pulling his/her legs apart to provide incontinence care. The resident stated he/she told the CNA that he had caused pain to him/her and he/she was going to "tell" on him.</p> <p>Interview with CNA #8 on 04/24/14 at 4:17 PM acknowledged he and CNA #7 had provided incontinence care for Resident #7 when the resident said it hurt "down there," referring to the perineal area. CNA #8 stated he did not recall the exact date of the incident related to Resident #7, but he had informed LPN #2 that the resident had complained that he had hurt his/her legs when he left the resident's room. CNA #8 stated he provided incontinence care to Resident #7 the following night and the resident asked him to be careful with his/her legs because he had hurt</p>	F 225		

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F 225	<p>Continued From page 10 them the night before.</p> <p>Interview with CNA #7 on 04/24/14 at 4:17 PM revealed he recalled Resident #7 had complained that CNA #8 had hurt him/her when the CNA "pulled" the resident's legs apart in order to provide incontinence care. Although CNA #7 stated he did not remember the exact date of the incident, he stated when they left the resident's room, he and CNA #8 informed LPN #2 of the statement Resident #7 had made when they had provided incontinence care.</p> <p>Interview with LPN #2 on 04/24/14 at 6:35 PM revealed CNA #8 reported to her that Resident #7 stated CNA #8 "broke" his/her "vagina"; however, LPN #2 could not recall the date of the report. LPN #2 further stated she went in Resident #7's room to assess the resident and did not "see anything broken." She stated the resident informed her CNA #8 "broke" his/her "vagina" and the resident was going to "tell" his/her spouse. LPN #2 stated she "think[s]" she "documented" the incident in the Nursing Notes of the resident's medical record at the time the CNA reported the incident to her. However, LPN #2 stated because there had been a "witness" in the room at the time of the incident, she did not "think" of the incident as abuse and did not remove the alleged perpetrator from direct resident care; she did not initiate an investigation of the incident, and did not report the resident's allegation to anyone.</p> <p>Review of Nursing Notes in Resident #7's medical record for January 2014 (the month the incident occurred based on documentation in the incident report) revealed no documentation the resident had made any complaints related to a "broke vagina" or of an incident that involved CNA</p>	F 225		

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F 225	<p>Continued From page 11 #8.</p> <p>Interview with RN #2 on 04/25/14 at 11:15 AM revealed she spoke to Resident #7 on 01/22/14 about his/her allegation. According to RN #2, Resident #7 believed that CNA #8 had intentionally hurt him/her while providing incontinence care on 01/18/14. RN #2 stated she contacted the Director of Nursing (DON) by telephone and reported the resident's allegation. RN #2 revealed at that time CNA #8 was in the facility and she was instructed by the DON to inform CNA #8 not to provide care to Resident #7, but CNA #8 could continue to provide direct care to all other residents in the facility. RN #2 stated that she talked to three residents CNA #8 had provided care to on 01/18/14, and none of the residents had complaints. RN #2 also stated no further investigation was conducted at that time and the allegation was not reported to the Administrator or other State Agencies, as required. According to RN #2 she had the responsibility to complete abuse investigations in the facility and was aware of the reporting requirements, but ultimately all decisions regarding reporting and disciplinary action were made by the Administrator and/or DON.</p> <p>Interview with the DON/Co-Owner on 04/24/14, at 5:05 PM revealed that because CNA #8 had denied intentionally harming Resident #8 when he provided incontinence care to the resident, and there had been a witness in the room who also denied CNA #8 had intentionally harmed the resident, she did not feel the allegation warranted further investigation.</p> <p>Interview with the Administrator/Co-Owner on 04/25/14, at 10:55 AM revealed that he or the</p>	F 225			

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F 225	<p>Continued From page 12</p> <p>DON made decisions regarding abuse investigations. The Administrator stated to the "best" of his "recollection" he was not informed of Resident #7's allegation of abuse made on 01/18/14, until 04/24/14, 95 days after the resident voiced the allegation.</p> <p>2. Review of Resident #5's medical record revealed the facility admitted the resident on 01/05/13. Review of a Quarterly Minimum Data Set (MDS) assessment dated 02/11/14, revealed the facility assessed Resident #5 to have a Brief Interview Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact with no memory deficits.</p> <p>Interview with Resident #5 on 04/23/14, at 10:15 AM revealed he/she had "been robbed" about a month ago (exact date unknown). Resident #5 stated six dollars (\$6.00) had been taken out of a drawer in his/her room during the night. Resident #5 stated he/she had reported to the "boss" that the money was missing and the facility reimbursed him/her the six dollars (\$6.00). Additionally, Resident #5 stated "two to three days ago" (exact date unknown) a pair of pants had also disappeared from his/her room.</p> <p>Interview on 04/23/14, at 2:50 PM with the Social Services Director/Activity Director (SSD/AD) revealed she generally took care of missing money or items. The SSD/AD stated when a resident reported they had missing money or items, she would replace the money and/or items. The SSD/AD stated at times the Administrator or DON may be aware of the missing items, but that no formal reporting system was in place for "small" amounts of money or "inexpensive" items. The SSD/AD stated that if a "large" amount of</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>money or an "expensive" item was reported missing. Administrative staff would be notified and an investigation initiated. However, the SSD/AD was unable to state how or who in the facility made the decision on what would be considered "large" and what warranted an investigation or was to be reported to Administration.</p> <p>3. Review of Resident #6's medical record revealed the facility admitted the resident on 08/30/13. Review of a Quarterly Minimum Data Set (MDS) assessment dated 02/25/14, revealed the facility assessed Resident #6 to have a BIMS score of 15, which indicated the resident's cognition was intact with no memory deficits.</p> <p>Review of a facility file containing written statements revealed on 02/03/14, Resident #6 reported to facility staff that thirty-six dollars (\$36.00) had been "stolen" from him/her. The staff reported the allegation made by Resident #6 to the nurse caring for the resident at the time.</p> <p>Interview on 04/25/14 at 11:30 AM revealed LPN #5 was notified on 02/03/14 that Resident #6 reported money had been stolen from him/her. LPN #5 stated she spoke to Resident #6 about the missing money and searched the resident's room but was unable to locate the money. LPN #5 stated she wrote a statement detailing the events of the incident, but took no further action to initiate an investigation or notify facility Administration about Resident #6's allegations that money had been stolen. LPN #5 stated the routine procedure in the facility was to notify an Activities staff member of any missing money reported by residents. LPN #5 stated she informed the Activity Assistant on 02/04/14 that</p>	F 225			

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F 225	<p>Continued From page 14</p> <p>Resident #6 reported ho/she had thirty-six dollars (\$36.00) missing.</p> <p>Interview on 04/24/14 at 3:25 PM with the Activity Assistant revealed she was informed on 02/04/14 that Resident #6 alleged thirty-six dollars (\$36.00) had been "stolen" from him/her. The Activity Assistant stated she spoke with Resident #6 about the money and then reimbursed the resident thirty-six dollars (\$36.00) from facility funds. The Activity Assistant stated since she had reimbursed Resident #6 for the missing money the allegation was not reported to the Administrator or other officials. The Activity Assistant stated if anyone reported a "large" amount of money was missing, she would notify facility Administration. However, the Activity Assistant was unable to define what specifically constituted a "large" amount of money, or what specific circumstances would prompt notification of Administration.</p> <p>Interview with the DON on 04/24/14, at 5:05 PM revealed when a resident reported missing money or an item, the facility staff would initiate a search for the item, and if it was not located the item or money was replaced by the facility. The DON confirmed the facility did not investigate when a resident reported a small amount of money or inexpensive item missing. The DON also acknowledged facility staff did not always inform her of all items that residents alleged to be missing. She stated the facility did not have a system in place to track or trend missing items in an attempt to determine if there was a pattern of when the incidents occurred, or to identify staff that had worked at the time the incidents had reportedly occurred.</p>	F 225			

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F 225	<p>Continued From page 15</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 05/05/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The allegation of abuse from 01/18/14 was reopened on 04/25/14 with all regulatory agencies being notified. All staff members alleged to be present during the 01/18/14 allegation including State Registered Nurse Aide (SRNA) #8 and Licensed Practical Nurse (LPN) #2 were removed from the schedule and suspended pending the conclusion of this investigation.</p> <p>To ensure the safety of Resident #7, as well as all other residents residing at this facility, on 04/25/14 residents with a Brief Interview for Mental Status (BIMS) score of 8 and above were interviewed by the Activity/Social Services Director and/or Minimum Data Set (MDS) Coordinator to determine if any had failed to report an allegation of abuse, neglect, misappropriation, or exploitation. No reports of physical abuse were noted from these interviews. These interviews did identify 13 residents who reported missing items/money. Investigations were started immediately by members of the Abuse Committee. The appropriate State agencies were notified of these allegations on 04/28/14.</p> <p>Residents with a BIMS score below 8 had a head to toe skin assessment done on 04/25/14 by nurses. Ten residents were identified with bruises/areas of discoloration/scratches and scabs. These were reviewed by the Director of Nursing (DON) and Consulting Nurses on 04/27/14, and although none were of suspicious nature, investigations were started on 04/27/14 by</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>the Quality Assurance (QA) Nurse and MDS Coordinators. The appropriate State agencies were notified on 04/28/14 by the MDS Coordinator. Investigations were concluded on 04/29/14 with all being unsubstantiated by the facility's QA Abuse Committee. On 05/01/14 and 05/02/14, the ten residents' investigations were reviewed again for possible causes of the injuries and what could be done to protect the resident from the reoccurrence of similar injuries.</p> <p>To ensure facility policy has been followed and the appropriate State agencies notified timely, members of the Abuse Committee, which are the DON, Social Services/Activity Director, MDS staff, QA Nurse, and Assistant Director of Nursing (ADON), reviewed on 05/01/14 all allegation reports from the year 2013 until present. The Abuse Committee reviewed daily all resident allegations, injuries of unknown origin, and any misappropriation of residents' property to ensure facility policy was followed and all notifications had been timely.</p> <p>All staff was interviewed by the ADON and the QA Nurse on 04/29/14 to determine if anyone had failed to report any allegations of abuse, neglect, misappropriation, or exploitation. There were no new allegations reported.</p> <p>The Nursing Home Administrator (NHA), DON, ADON, QA Nurse, Activity/Social Services Director, Resident Care Supervisor, MDS Coordinators, Medical Records Director, Data Compliance staff, and Office Assistant received in-service education by the Nurse Consultant on 04/25/14 regarding the regulatory requirements on reporting, investigation, and protection of residents with all allegations of abuse, neglect,</p>	F 225			

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F 225	<p>Continued From page 17</p> <p>misappropriation, and exploitation. On 05/01/14, additional in-service was provided by the Nurse Consultant on using the handouts provided at a seminar given by the Office of Inspector General on 02/26/14.</p> <p>Staff was in-serviced by the QA Nurse and/or the DON on April 25, April 26, April 27, and April 28, 2014 on the following items: investigating abuse, neglect, misappropriation, when to investigate, reporting abuse, neglect, misappropriation, collecting statements for investigations, performing head to toe assessments on residents when allegations are made to ensure the resident has no injury, notifying the Administrator, DON, ADON, and appropriate State agencies, when to call 911 for on-call Social Worker, resident's physician, and responsible party, protecting residents by removal of accused immediately, and removing resident(s) immediately out of harm's way.</p> <p>In-service was held on 05/01/14 with all LPNs, SRNAs, Certified Medication Technicians (CMTs), office staff, kitchen staff, housekeeping staff, laundry staff, maintenance staff, and janitorial staff attending. In-service was given by the DON. Two employees were not present at either meeting and those two employees were in-serviced on 05/02/14 by the DON. Information for the in-service included the training manual, "Hand in Hand: A Training Series for Nursing Homes." The in-service covered the following listed areas: revised abuse policy, revised investigation form, types of abuse, how to report abuse, protection of resident, preventing abuse, what constitutes abuse, LPNs starting investigation (what to do), allegations of abuse, identifying abuse, screening potential employees,</p>	F 225			

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F 225	<p>Continued From page 18 and revised reporting protocol for abuse.</p> <p>A posttest was given on 05/01/14 to all staff after each of the in-services on examples related to abuse issues. The two employees in-serviced on 05/02/14 were given the posttest also. Employees who did not score 100 percent on their test were rein-serviced at the time the posttest was reviewed by the DON.</p> <p>As an ongoing training program, all new hires will be required to go through the abuse training that will include the following: screening, training, prevention, identification, investigation, protection, and reporting/response. Information for these trainings will be taken from the manual, "Hand in Hand: A Training Series for Nursing Homes." After these in-services, the new employee will be required to take a posttest to ensure they understand all issues related to abuse.</p> <p>In-services on abuse will be done monthly for a period of six months. The monthly abuse in-services will be conducted by either the DON or her designated staff member. Posttests will be done after each abuse in-service. All staff will be required to attend the monthly abuse in-services.</p> <p>Payroll Employee #1, the Office Manager, and Accounts Payable were in-serviced on the following revised policies and procedures by the ADON on 04/28/14: screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>Payroll Employee #1, the Office Manager, and Accounts Payable staff have reviewed all current employee files on the following to ensure current employees have no offences that would prevent</p>	F 225		

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F 225	<p>Continued From page 19</p> <p>them from working at this facility: Abuse Registry, Kentucky Court of Justice, local County Police Department, and the OIG Exclusion.</p> <p>The following policies and procedures have been revised by the DON and ADON: screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>The DON and Administrator have reviewed all employee files and signed off on them as of 04/29/14 indicating all current employees have no record that would prevent them from working at a long-term care facility.</p> <p>The facility QA team (DON, ADON, QA Nurse, MDS Coordinator, and Social Services/Activity Director) met with the Medical Director on 04/29/14 to review the circumstances of the allegation and all interventions which had been and will be implemented by the facility.</p> <p>The Administrator or his designee will be responsible for completing a thorough investigation of all allegations including the following: notifying appropriate State agencies timely, notifying residents' family and Physician timely, prevent further potential abuse, review the results of the investigation process and take any corrective action required such as retraining, disciplinary action, faxing information to agencies, and ensuring residents have been and are being protected.</p> <p>Members of the Abuse Committee will meet daily and review the following: all incident reports from the previous 24 hours, all investigations, all injuries of unknown origin, all allegations of</p>	F 225		

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F 225	<p>Continued From page 20</p> <p>misappropriation, and all other allegations.</p> <p>It will be the responsibility of the Abuse Committee to make the determination that an allegation is or is not substantiated.</p> <p>Members of the Abuse Committee will also be responsible for ensuring daily interviews are completed with five residents and five employees. Interviews were conducted with staff and residents seven days a week until the Immediate Jeopardy (IJ) was removed. Employee interviews were done on a random basis and included all shifts and all departments. After the IJ is removed, staff will continue to do staff and resident interviews weekly for six months to ensure all allegations are reported.</p> <p>A log will be maintained by the Abuse Committee to ensure five different residents and five different employees from different departments are interviewed daily. These interviews will be maintained in a log along with any allegations identified from the interviews. Investigations will be initiated immediately on any allegation identified from the interviews. All investigation information will also be maintained in the log. The information from these interviews will be reviewed daily by members of the Abuse Committee for any allegations and related investigations.</p> <p>It is the responsibility of the Abuse Committee to ensure all allegations are handled in a timely manner with all agencies being notified timely. The Continuous Quality Improvement (CQI) indicator for the monitoring of compliance with the components of the abuse regulation, including but not limited to investigating and reporting of abuse.</p>	F 225			

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F 225	<p>Continued From page 21</p> <p>will be utilized (during and at the conclusion of the investigation) with each allegation of abuse for four weeks, then monthly for four months, and then quarterly thereafter under the supervision of the Administrator and DON.</p> <p>Results of each abuse allegation CQI indicator will be reviewed by the QA team as part of the daily meetings, Monday through Friday, to ensure all allegations were handled correctly. The results of these CQI indicators will also serve as ongoing information to see where the facility's weak areas are with the seven components of abuse and neglect and in-services will be conducted related to these areas.</p> <p>Daily oversight related to the findings of the completed CQI indicators will be reviewed by the contracted Nurse Consultant by e-mail to ensure all allegations are investigated and reported as indicated. Monthly visits to the facility will also be done by the Nurse Consultant.</p> <p>The facility's Abuse policies and procedures have been reviewed and revised by the DON, ADON, and Administrator.</p> <p>Information from the QA Committee and Abuse Committee will be given to the Administrator daily for his review. This information will include the following: all allegations of abuse, all abuse investigations and conclusions, QA findings, all allegations of misappropriation of property, all other allegations, and minutes from the QA Committee and Abuse Committee.</p> <p>It will be the Administrator's responsibility to oversee all aspects of this Allegation of Compliance.</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>The following policies and procedures have been revised with most of the content being changed: resident Abuse Policy, QA Abuse Investigating Team, form for complaint of abuse, form for reporting misappropriation of property, reporting protocol, check list of initial investigation, Nurse's instructions for initial allegations, initial allegation of abuse and neglect form, policy on resident protection during abuse investigation, reporting on injury of unknown origin policy, missing items monitoring form, initial investigation of misappropriation of property, policy on misappropriation of resident's property, and complaint/grievance report form.</p> <p>**The surveyors validated the immediate Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interview with the DON on 05/07/14 at 3:45 PM verified the allegation of abuse by Resident #7 had been reopened and SRNA #8 and LPN #2 had been suspended during the investigation.</p> <p>Interview on 05/07/14 at 2:45 PM with the Activity/Social Services Director revealed all alert and oriented residents with a Brief Interview for Mental Status (BIMS) score of 8 and above had been interviewed regarding abuse and staff treatment and no concerns related to physical abuse or neglect were identified.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM and the Activity/Social Services Director at 2:45 PM revealed 13 residents had been identified during interview who reported missing money/items. Interview and review of the facility's Allegation of Compliance binder revealed</p>	F 225		

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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 50 BYPASS MONTICELLO, KY 42633	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 23</p> <p>the items/money had either been found or replaced and the appropriate State agencies had been notified.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 05/07/14 at 2:23 PM, and LPN #5 on 05/07/14 at 2:38 PM revealed they completed skin assessments on residents with BIMS scores below 8. Interview revealed some of the residents assessed had bruising/skin tears; however, none of the areas observed were of a suspicious nature.</p> <p>Interview on 05/07/14 at 3:45 PM with the DON and review of the facility's Allegation of Compliance binder revealed during the skin assessments any areas identified on a resident were reviewed by the DON and investigations were initiated, even though they were not of a suspicious nature. Further review revealed the appropriate State agencies had been notified.</p> <p>Interview on 05/07/14 at 3:45 PM with the Director of Nursing (DON), the Quality Assurance Nurse at 2:15 PM, the Assistant Director of Nursing (ADON) at 2:00 PM, and the Minimum Data Set (MDS) Nurse at 1:45 PM revealed they were a part of the Abuse Committee and had met daily and reviewed all allegations of abuse as a team. The Committee reviewed all allegations from the beginning of 2013 until present to ensure they had been investigated, protection had been provided, and they were reported timely to the appropriate agencies. Further, the Committee only identified a problem with one, which was reopened and investigated and no concerns were identified so it was unsubstantiated.</p> <p>Interview on 05/07/14 with LPN #4 at 2:43 PM.</p>	F 225		

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F 225	<p>Continued From page 24</p> <p>LPN #6 at 2:38 PM, SRNA #16 at 3:00 PM, and SRNA #15 at 3:10 PM revealed they had been interviewed regarding any abuse which may not have been reported. All staff interviewed denied any further knowledge of abuse.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM revealed they did receive in-service by the Nurse Consultant on 04/25/14 regarding regulatory requirements on reporting, investigation, and protection of residents with all allegations of abuse, neglect, misappropriation, and exploitation. Further interview revealed they also received in-service on 05/01/14 on using the handouts provided at a seminar by the Office of Inspector General.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 with the QA Nurse at 2:07 PM, the DON at 3:45 PM, LPN #4 at 2:43 PM, LPN #6 at 2:38 PM, SRNA #16 at 3:00 PM, and SRNA #15 at 3:10 PM revealed in-service was conducted for all staff regarding all components of abuse. Further interview with the LPNs, SRNAs, and the DON revealed another in-service was held on 05/01/14 using the training, "Hand in Hand: A Training Series for Nursing Homes." The staff stated they did take a posttest after the in-service.</p> <p>Interview with Payroll Employee #1 on 05/07/14 at 1:00 PM revealed the facility had not hired any new employees since 05/03/14.</p> <p>Review of the facility's Allegation of Compliance binder and interview with the ADON on 05/07/14</p>	F 225		

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F 225	<p>Continued From page 25</p> <p>at 2:00 PM revealed Payroll Employee #1, the Office Manager, and Accounts Payable staff had been in-serviced regarding revised policies/procedures regarding screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 at 1:50 PM with Payroll Employee #1 revealed all current employee files had been reviewed to ensure no current employee had an offence that would prevent them from working at a nursing facility.</p> <p>Interview with the DON on 05/07/14 at 3:45 PM and review of the following policy/procedures revealed they had been revised: screening of potential employees (revision date 04/25/14), criminal record background checks (revision date 04/25/14), and reference checks on potential employees (not dated).</p> <p>Interview with the DON on 05/07/14 at 3:45 PM revealed she and the Administrator had reviewed all current employee files.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM revealed the QA team had met with the Medical Director on 04/29/14 to ensure he was aware of the Immediate Jeopardy (IJ) and the interventions which had been put in place by the facility.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45</p>	F 225			

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F 225	<p>Continued From page 28</p> <p>PM, who are members of the Abuse Committee, revealed the Committee had met daily and reviewed incident reports each day from the previous 24 hours, all investigations, all injuries of unknown origin, all allegations of misappropriation, and all other allegations. Further interview revealed the Committee was making the final decision on all investigations as to whether it was substantiated or not. Interview and review of the facility's Allegation of Compliance binder further revealed the Abuse Committee had been conducting five interviews daily with residents and staff regarding abuse and staff treatment of residents. Interview and review of the facility's Allegation of Compliance binder further revealed the facility was maintaining a log of all allegations and investigations to ensure they were initiated immediately. Interview further revealed the facility was utilizing the CQI tool for all allegations of abuse.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, and the QA Nurse at 2:07 PM revealed the QA team was meeting daily, Monday through Friday, and the CQI tool was being reviewed during the meeting.</p> <p>Policy review and interview with the DON on 05/07/14 at 3:45 PM revealed the facility's Abuse Policy and Procedure had been reviewed and revised.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM revealed all information from the Abuse Committee and the QA Committee was given daily to the Administrator for his review.</p> <p>Policy review and interview on 05/07/14 at 3:45 PM with the DON revealed the following</p>	F 225			

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F 225	Continued From page 27 policy/procedures had been revised: resident Abuse Policy, QA Abuse Investigating Team, complaint of abuse form, form for reporting misappropriation of property, reporting protocol, check list of initial investigation, Nurse's instructions for initial allegations, initial allegation of abuse and neglect form, policy on resident protection during abuse investigation, reporting on injury of unknown origin policy, missing items monitoring form, initial investigation of misappropriation of property, policy on misappropriation of resident's property, and complaint/grievance report form.	F 225			
F 226 SS=J	483.13(c) DEVELOP/IMPLEMENT 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 interview and record review it was determined the facility failed to ensure policies and procedures that prohibited neglect, mistreatment, and abuse had been implemented for three (3) of four (4) sampled residents (Residents #7, #5, and #6). The facility failed to ensure all allegations were investigated and failed to ensure residents were protected from further potential abuse during the facility's investigation. Record review and interviews revealed Resident #7 informed Certified Nurse Aides (CNAs) #7 and #8 that CNA #8 hurt the resident when they	F 226	Please See Attachment F226	F 226	

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F 226	<p>Continued From page 28</p> <p>provided incontinence care to him/her. CNAs #7 and #8 informed Licensed Practical Nurse (LPN) #2 of the resident's complaint when they (CNAs #7 and #8) left the resident's room; however, LPN #2 did not report the incident.</p> <p>On 01/22/14, Resident #7 informed Registered Nurse (RN) #3 that CNA #8 hurt him/her when he provided incontinence care to the resident, and RN #3 reported the allegation to RN #2 and the DON. RN #2 interviewed Resident #7 and informed the DON of her findings. The DON stated in interview on 04/24/14 at 5:05 PM that due to witnesses being present who denied CNA #8 had intentionally hurt Resident #7 (on 01/18/14), she advised staff that CNA #8 could continue to provide care to other facility residents, but that CNA #8 would not be allowed to provide direct care to Resident #7. The DON stated she did not report the allegation to the Administrator of the facility and State agencies as required. In addition, review of the facility's investigation revealed the facility took no action to protect residents from further abuse/potential abuse until 04/24/14 (95 days after the allegation of abuse) when the facility removed CNA #8 from direct patient care.</p> <p>Resident #5 reported to facility staff (around 04/18/14, exact date unknown) that six dollars (\$6.00) and a pair of pants were missing from his/her room; and on 02/04/14, Resident #6 reported that thirty-six dollars (\$36.00) was missing from his/her room. The facility reimbursed Residents #5 and #6 for the reported missing monies; however, the facility failed to conduct an investigation or report the possible misappropriation of resident property to the appropriate State agencies as required.</p>	F 226			

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F 226	<p>Continued From page 29</p> <p>The facility's failure to implement policies and procedures that prohibited neglect, mistreatment, and abuse that included reporting allegations of abuse, protecting residents during the course of their investigation, and conducting an investigation of an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 01/18/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 483.75 Administration (F490) with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). The facility was notified of the Immediate Jeopardy on 04/24/14.</p> <p>On 05/06-07/14, a partial extended survey was conducted. An acceptable Allegation of Compliance was received on 05/05/14 which alleged removal of the Immediate Jeopardy on 05/03/14. The State Agency determined the Immediate Jeopardy was removed on 05/03/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>According to the facility's policy, "Resident Abuse," not dated, the facility would immediately report, and thoroughly investigate, all allegations of mistreatment, neglect, abuse, and misappropriation of resident property, and would immediately report all alleged incidents involving</p>	F 226			

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F 228	<p>Continued From page 30</p> <p>mistreatment, abuse, or misappropriation of resident property to the facility Administrator. The policy revealed the facility would prevent further potential abuse during the course of the investigation, including the removal of alleged staff from the care of all residents. The policy also revealed the Administrator/designee would immediately notify the appropriate State agencies of the allegation.</p> <p>1. Documentation in Resident #7's medical record revealed the facility admitted the resident on 12/19/12. Review of a Minimum Data Set (MDS) assessment dated 02/17/14, revealed the facility assessed Resident #7 to have a Brief Interview of Mental Status (BIMS) score of 12, which indicated the resident's cognition was moderately impaired.</p> <p>Based on documentation on a "Complaint of Abuse/Neglect" form, not dated and not signed, on 01/22/14 Resident #7 reported to Registered Nurse (RN) #3 that CNA #8 hurt him/her when he provided incontinence care to the resident (approximately four days earlier), and RN #3 reported the allegation to RN #2 and the DON. RN #2 completed an incident report and interviewed Resident #7. Continued review of the report revealed Resident #7 informed RN #2 that CNA #8 was "always rough" with him/her. The resident further stated he/she "told" the CNA he was hurting him/her and he started "laughing" and said "you are just being a timid [boy/girl]."</p> <p>Resident #7 acknowledged in an interview conducted on 04/24/14 at 10:30 AM that he/she had reported Certified Nurse Aide (CNA) #8 "hurt me." The resident was unable to recall the exact date of the incident and stated CNA #8</p>	F 228			

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F 228	<p>Continued From page 31</p> <p>intentionally caused pain to the resident by forcibly pulling the resident's legs apart to provide incontinence care.</p> <p>CNA #8 stated in an interview conducted on 04/24/14 at 4:17 PM that he and CNA #7 had provided incontinence care for Resident #7, the resident told them it hurt "down there," and CNA #8 informed LPN #2. Continued interview with CNA #8 revealed he provided incontinence care to Resident #7 the following night and the resident asked him to be careful with his/her legs because he had hurt them the night before.</p> <p>CNA #7 stated in interview on 04/24/14 at 4:17 PM that Resident #7 had complained that CNA #8 had hurt the resident when the CNA "pulled" the resident's legs apart in order to provide incontinence care. CNA #7 stated he did not remember the exact date of the incident, but stated he and CNA #8 informed Licensed Practical Nurse (LPN) #2 of the resident's complaint.</p> <p>LPN #2 confirmed in interview conducted on 04/24/14 at 6:35 PM that CNA #8 reported to her Resident #7 had complained about the care CNA #8 provided; however, LPN #2 could not recall the date of the report. LPN #2 further stated she assessed the resident and that she "think[s]" she "documented" the incident in the Nursing Notes of the resident's medical record. LPN #2 stated there had been a "witness" in the room at the time of the incident and she did not "think" abuse had occurred and she did not remove the alleged perpetrator from direct resident care, did not initiate an investigation of the incident, and did not report the resident's allegation to anyone.</p>	F 226			

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F 226	<p>Continued From page 32</p> <p>RN #2 stated in an interview conducted on 04/25/14 at 11:15 AM she spoke to Resident #7 on 01/22/14 about his/her allegation and reported the allegation to the Director of Nursing (DON) by telephone. Further interview with RN #2 revealed CNA #8 was in the facility at that time and she was instructed by the DON to inform CNA #8 not to provide care to Resident #7, but that he could continue to provide direct care to all other residents in the facility. RN #2 stated that she talked to three residents that CNA #8 had provided care to on 01/18/14, and none of the residents had voiced complaints. RN #2 also stated no further investigation was conducted at that time and the allegation was not reported to the Administrator or other State Agencies as required. According to RN #2 she had the responsibility to complete abuse investigations in the facility and was aware of the reporting requirements, but ultimately all decisions regarding reporting and disciplinary action were made by the Administrator and/or DON.</p> <p>The DON/Co-Owner stated in interview conducted on 04/24/14, at 5:05 PM that because CNA #8 had denied intentionally harming Resident #8 when he provided incontinence care to the resident, and there had been a witness in the room who also denied CNA #8 had intentionally harmed the resident, she did not feel the allegation warranted further investigation.</p> <p>The Administrator/Co-Owner stated in interview on 04/25/14, at 10:55 AM that he or the DON determined the actions to take when an allegation of abuse was made. The Administrator stated to the "best" of his "recollection" he was not informed of Resident #7's allegation of abuse made on 01/18/14, until 04/24/14, 95 days after</p>	F 226		

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F 226	<p>Continued From page 33 the resident voiced the allegation.</p> <p>2. Resident #5's medical record revealed the facility admitted the resident on 01/05/13. Review of a Quarterly Minimum Data Set (MDS) assessment dated 02/11/14, revealed the facility assessed Resident #5 to have a BIMS score of 15, which indicated the resident's cognition was intact.</p> <p>Resident #5 stated in interview on 04/23/14, at 10:15 AM that six dollars (\$6.00) had been taken from his/her room during the night approximately one month ago (exact date unknown). Resident #5 reported to the "boss" that the money had been taken, and was reimbursed six dollars (\$6.00). Additionally, Resident #5 stated a pair of pants had also disappeared from his/her room two to three days ago (exact date unknown).</p> <p>In interview on 04/23/14, at 2:50 PM the Social Services Director/Activity Director (SSD/AD) stated when a resident reported missing money or items, the money would be reimbursed to the resident or the missing item replaced. However, the SSD/AD stated the Administrator would not be notified unless the money or item was of substantial value. The SSD/AD stated if a "large" amount of money or an "expensive" item was reported missing, Administrative staff would be notified and an investigation initiated. However, the SSD/AD was unable to state how or who in the facility made the decision on what would be reported to the Administrator or warrant an investigation.</p> <p>3. The facility admitted Resident #6 on 08/30/13. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment dated 02/25/14, revealed</p>	F 226			

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F 226	<p>Continued From page 34</p> <p>the resident was cognitively intact with no memory defects.</p> <p>Review of written statements made by facility staff revealed on 02/03/14, Resident #6 reported thirty-six dollars (\$36.00) had been "stolen" from him/her. The staff reported the allegation to Resident #6's nurse on 02/03/14.</p> <p>Interview conducted on 04/25/14 at 11:30 AM with LPN #5 revealed she had been notified on 02/03/14 that Resident #6 had reported missing money. LPN #5 stated she searched Resident #6's room but was unable to locate the money. Although LPN #5 wrote a statement detailing the events of the incident, she took no action to initiate an investigation or notify facility Administration about Resident #6's allegations that money had been stolen. LPN #5 stated the only action she took was notifying the Activity Assistant on 02/04/14 that Resident #6 had reported thirty-six dollars (\$36.00) had been stolen.</p> <p>In an interview conducted on 04/24/14 at 3:25 PM the Activity Assistant stated when she was notified of Resident #6's allegations, she reimbursed the resident thirty-six dollars (\$36.00) from facility funds. The Activity Assistant stated since the facility reimbursed Resident #6 for the missing money the allegation was not reported to the Administrator or other officials. The Activity Assistant was unable to define what specific circumstances would prompt notification of Administration in relation to resident allegations of missing money.</p> <p>In interview on 04/24/14, at 5:05 PM the DON stated when a resident reported missing money</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
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F 226	<p>Continued From page 35</p> <p>or an item, the facility staff would initiate a search for the item, and if it was not located the item or money was replaced by the facility. The DON confirmed the facility did not investigate when a resident reported a small amount of money or inexpensive item missing. The DON stated she was aware that the facility's policy/procedure indicated an investigation would be initiated for all allegations of misappropriation of resident property but stated since it was a "small facility" it was "easier" to reimburse the resident the money or replace inexpensive items.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 06/05/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The allegation of abuse from 01/18/14 was reopened on 04/25/14 with all regulatory agencies being notified. All staff members alleged to be present during the 01/18/14 allegation including State Registered Nurse Aide (SRNA) #8 and Licensed Practical Nurse (LPN) #2 were removed from the schedule and suspended pending the conclusion of this investigation.</p> <p>To ensure the safety of Resident #7, as well as all other residents residing at this facility, on 04/25/14 residents with a Brief Interview for Mental Status (BIMS) score of 8 and above were interviewed by the Activity/Social Services Director and/or Minimum Data Set (MDS) Coordinator to determine if any had failed to report an allegation of abuse, neglect, misappropriation, or exploitation. No reports of physical abuse were noted from these interviews. These interviews did identify 13 residents who reported missing items/money. Investigations</p>	F 226			

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F 226	<p>Continued From page 36</p> <p>were started immediately by members of the Abuse Committee. The appropriate State agencies were notified of these allegations on 04/28/14.</p> <p>Residents with a BIMS score below 8 had a head to toe skin assessment done on 04/25/14 by nurses. Ten residents were identified with bruises/areas of discoloration/scratches and scabs. These were reviewed by the Director of Nursing (DON) and Consulting Nurses on 04/27/14, and although none were of suspicious nature, investigations were started on 04/27/14 by the Quality Assurance (QA) Nurse and MDS Coordinators. The appropriate State agencies were notified on 04/28/14 by the MDS Coordinator. Investigations were concluded on 04/29/14 with all being unsubstantiated by the facility's QA Abuse Committee. On 05/01/14 and 05/02/14, the ten residents' investigations were reviewed again for possible causes of the injuries and what could be done to protect the resident from the recurrence of similar injuries.</p> <p>To ensure facility policy has been followed and the appropriate State agencies notified timely, members of the Abuse Committee, which are the DON, Social Services/Activity Director, MDS staff, QA Nurse, and Assistant Director of Nursing (ADON), reviewed on 05/01/14 all allegation reports from the year 2013 until present. The Abuse Committee reviewed daily all resident allegations, injuries of unknown origin, and any misappropriation of residents' property to ensure facility policy was followed and all notifications had been timely.</p> <p>All staff was interviewed by the ADON and the QA Nurse on 04/29/14 to determine if anyone had</p>	F 226			

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F 226	<p>Continued From page 37</p> <p>failed to report any allegations of abuse, neglect, misappropriation, or exploitation. There were no new allegations reported.</p> <p>The Nursing Home Administrator (NHA), DON, ADON, QA Nurse, Activity/Social Services Director, Resident Care Supervisor, MDS Coordinators, Medical Records Director, Data Compliance staff, and Office Assistant received in-service education by the Nurse Consultant on 04/25/14 regarding the regulatory requirements on reporting, investigation, and protection of residents with all allegations of abuse, neglect, misappropriation, and exploitation. On 05/01/14, additional in-service was provided by the Nurse Consultant on using the handouts provided at a seminar given by the Office of Inspector General on 02/26/14.</p> <p>Staff was in-serviced by the QA Nurse and/or the DON on April 25, April 26, April 27, and April 28, 2014 on the following items: investigating abuse, neglect, misappropriation, when to investigate, reporting abuse, neglect, misappropriation, collecting statements for investigations, performing head to toe assessments on residents when allegations are made to ensure the resident has no injury, notifying the Administrator, DON, ADON, and appropriate State agencies, when to call 911 for on-call Social Worker, resident's physician, and responsible party, protecting residents by removal of accused immediately, and removing resident(s) immediately out of harm's way.</p> <p>In-service was held on 05/01/14 with all LPNs, SRNAs, Certified Medication Technicians (CMTs), office staff, kitchen staff, housekeeping staff, laundry staff, maintenance staff, and janitorial</p>	F 226			

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F 226	<p>Continued From page 38</p> <p>staff attending. In-service was given by the DON. Two employees were not present at either meeting and those two employees were in-serviced on 05/02/14 by the DON. Information for the in-service included the training manual, "Hand in Hand: A Training Series for Nursing Homes." The in-service covered the following listed areas: revised abuse policy, revised investigation form, types of abuse, how to report abuse, protection of resident, preventing abuse, what constitutes abuse, LPNs starting investigation (what to do), allegations of abuse, identifying abuse, screening potential employees, and revised reporting protocol for abuse.</p> <p>A posttest was given on 05/01/14 to all staff after each of the in-services on examples related to abuse issues. The two employees in-serviced on 05/02/14 were given the posttest also. Employees who did not score 100 percent on their test were re-in-serviced at the time the posttest was reviewed by the DON.</p> <p>As an ongoing training program, all new hires will be required to go through the abuse training that will include the following: screening, training, prevention, identification, investigation, protection, and reporting/response. Information for these trainings will be taken from the manual, "Hand in Hand: A Training Series for Nursing Homes." After these in-services, the new employee will be required to take a posttest to ensure they understand all issues related to abuse.</p> <p>In-services on abuse will be done monthly for a period of six months. The monthly abuse in-services will be conducted by either the DON or her designated staff member. Posttests will be done after each abuse in-service. All staff will be</p>	F 226		

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F 226	<p>Continued From page 39 required to attend the monthly abuse in-services.</p> <p>Payroll Employee #1, the Office Manager, and Accounts Payable were in-serviced on the following revised policies and procedures by the ADON on 04/28/14: screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>Payroll Employee #1, the Office Manager, and Accounts Payable staff have reviewed all current employee files on the following to ensure current employees have no offences that would prevent them from working at this facility: Abuse Registry, Kentucky Court of Justice, local County Police Department, and the OIG Exclusion.</p> <p>The following policies and procedures have been revised by the DON and ADON: screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>The DON and Administrator have reviewed all employee files and signed off on them as of 04/29/14 indicating all current employees have no record that would prevent them from working at a long-term care facility.</p> <p>The facility QA team (DON, ADON, QA Nurse, MDS Coordinator, and Social Services/Activity Director) met with the Medical Director on 04/29/14 to review the circumstances of the allegation and all interventions which had been and will be implemented by the facility.</p> <p>The Administrator or his designee will be responsible for completing a thorough investigation of all allegations including the</p>	F 226			

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F 226	<p>Continued From page 40</p> <p>following: notifying appropriate State agencies timely, notifying residents' family and Physician timely, prevent further potential abuse, review the results of the investigation process and take any corrective action required such as retraining, disciplinary action, faxing information to agencies, and ensuring residents have been and are being protected.</p> <p>Members of the Abuse Committee will meet daily and review the following: all incident reports from the previous 24 hours, all investigations, all injuries of unknown origin, all allegations of misappropriation, and all other allegations.</p> <p>It will be the responsibility of the Abuse Committee to make the determination that an allegation is or is not substantiated.</p> <p>Members of the Abuse Committee will also be responsible for ensuring daily interviews are completed with five residents and five employees. Interviews were conducted with staff and residents seven days a week until the Immediate Jeopardy (IJ) was removed. Employee interviews were done on a random basis and included all shifts and all departments. After the IJ is removed, staff will continue to do staff and resident interviews weekly for six months to ensure all allegations are reported.</p> <p>A log will be maintained by the Abuse Committee to ensure five different residents and five different employees from different departments are interviewed daily. These interviews will be maintained in a log along with any allegations identified from the interviews. Investigations will be initiated immediately on any allegation identified from the interviews. All investigation</p>	F 226			

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F 226	<p>Continued From page 41</p> <p>information will also be maintained in the log. The information from these interviews will be reviewed daily by members of the Abuse Committee for any allegations and related investigations.</p> <p>It is the responsibility of the Abuse Committee to ensure all allegations are handled in a timely manner with all agencies being notified timely. The Continuous Quality Improvement (CQI) indicator for the monitoring of compliance with the components of the abuse regulation, including but not limited to investigating and reporting of abuse, will be utilized (during and at the conclusion of the investigation) with each allegation of abuse for four weeks, then monthly for four months, and then quarterly thereafter under the supervision of the Administrator and DON.</p> <p>Results of each abuse allegation CQI indicator will be reviewed by the QA team as part of the daily meetings, Monday through Friday, to ensure all allegations were handled correctly. The results of these CQI indicators will also serve as ongoing information to see where the facility's weak areas are with the seven components of abuse and neglect and in-services will be conducted related to these areas.</p> <p>Daily oversight related to the findings of the completed CQI indicators will be reviewed by the contracted Nurse Consultant by e-mail to ensure all allegations are investigated and reported as indicated. Monthly visits to the facility will also be done by the Nurse Consultant.</p> <p>The facility's Abuse policies and procedures have been reviewed and revised by the DON, ADON, and Administrator.</p>	F 226			

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F 226	<p>Continued From page 42</p> <p>Information from the QA Committee and Abuse Committee will be given to the Administrator daily for his review. This information will include the following: all allegations of abuse, all abuse investigations and conclusions, QA findings, all allegations of misappropriation of property, all other allegations, and minutes from the QA Committee and Abuse Committee.</p> <p>It will be the Administrator's responsibility to oversee all aspects of this Allegation of Compliance.</p> <p>The following policies and procedures have been revised with most of the content being changed: resident Abuse Policy, QA Abuse Investigating Team, form for complaint of abuse, form for reporting misappropriation of property, reporting protocol, check list of initial investigation, Nurse's instructions for initial allegations, initial allegation of abuse and neglect form, policy on resident protection during abuse investigation, reporting on injury of unknown origin policy, missing items monitoring form, initial investigation of misappropriation of property, policy on misappropriation of resident's property, and complaint/grievance report form.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interview with the DON on 05/07/14 at 3:45 PM verified the allegation of abuse by Resident #7 had been reopened and SRNA #8 and LPN #2 had been suspended during the investigation.</p> <p>Interview on 05/07/14 at 2:45 PM with the</p>	F 226		

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F 226	<p>Continued From page 43</p> <p>Activity/Social Services Director revealed all alert and oriented residents with a Brief Interview for Mental Status (BIMS) score of 8 and above had been interviewed regarding abuse and staff treatment and no concerns related to physical abuse or neglect were identified.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM and the Activity/Social Services Director at 2:45 PM revealed 13 residents had been identified during interview who reported missing money/items. Interview and review of the facility's Allegation of Compliance binder revealed the items/money had either been found or replaced and the appropriate State agencies had been notified.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 05/07/14 at 2:23 PM, and LPN #5 on 05/07/14 at 2:38 PM revealed they completed skin assessments on residents with BIMS scores below 8. Interview revealed some of the residents assessed had bruising/skin tears; however, none of the areas observed were of a suspicious nature.</p> <p>Interview on 05/07/14 at 3:45 PM with the DON and review of the facility's Allegation of Compliance binder revealed during the skin assessments any areas identified on a resident were reviewed by the DON and investigations were initiated, even though they were not of a suspicious nature. Further review revealed the appropriate State agencies had been notified.</p> <p>Interview on 05/07/14 at 3:45 PM with the Director of Nursing (DON), the Quality Assurance Nurse at 2:15 PM, the Assistant Director of Nursing (ADON) at 2:00 PM, and the Minimum</p>	F 226			

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F 226	<p>Continued From page 44</p> <p>Data Set (MDS) Nurse at 1:45 PM revealed they were a part of the Abuse Committee and had met daily and reviewed all allegations of abuse as a team. The Committee reviewed all allegations from the beginning of 2013 until present to ensure they had been investigated, protection had been provided, and they were reported timely to the appropriate agencies. Further, the Committee only identified a problem with one, which was reopened and investigated and no concerns were identified so it was unsubstantiated.</p> <p>Interview on 05/07/14 with LPN #4 at 2:43 PM, LPN #8 at 2:38 PM, SRNA #16 at 3:00 PM, and SRNA #15 at 3:10 PM revealed they had been interviewed regarding any abuse which may not have been reported. All staff interviewed denied any further knowledge of abuse.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM revealed they did receive in-service by the Nurse Consultant on 04/25/14 regarding regulatory requirements on reporting, investigation, and protection of residents with all allegations of abuse, neglect, misappropriation, and exploitation. Further interview revealed they also received in-service on 05/01/14 on using the handouts provided at a seminar by the Office of Inspector General.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 06/07/14 with the QA Nurse at 2:07 PM, the DON at 3:45 PM, LPN #4 at 2:43 PM, LPN #6 at 2:38 PM, SRNA #16 at 3:00 PM, and SRNA #15 at 3:10 PM revealed in-service was conducted for all staff regarding all</p>	F 226		

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F 226	<p>Continued From page 45</p> <p>components of abuse. Further interview with the LPNs, SRNAs, and the DON revealed another in-service was held on 05/01/14 using the training, "Hand in Hand: A Training Series for Nursing Homes." The staff stated they did take a posttest after the in-service.</p> <p>Interview with Payroll Employee #1 on 05/07/14 at 1:00 PM revealed the facility had not hired any new employees since 05/03/14.</p> <p>Review of the facility's Allegation of Compliance binder and interview with the ADON on 05/07/14 at 2:00 PM revealed Payroll Employee #1, the Office Manager, and Accounts Payable staff had been in-serviced regarding revised policies/procedures regarding screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 at 1:50 PM with Payroll Employee #1 revealed all current employee files had been reviewed to ensure no current employee had an offence that would prevent them from working at a nursing facility.</p> <p>Interview with the DON on 05/07/14 at 3:45 PM and review of the following policy/procedures revealed they had been revised: screening of potential employees (revision date 04/25/14), criminal record background checks (revision date 04/25/14), and reference checks on potential employees (not dated).</p> <p>Interview with the DON on 05/07/14 at 3:45 PM revealed she and the Administrator had reviewed all current employee files.</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
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F 226	<p>Continued From page 48</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM revealed the QA team had met with the Medical Director on 04/29/14 to ensure he was aware of the Immediate Jeopardy (IJ) and the interventions which had been put in place by the facility.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM, who are members of the Abuse Committee, revealed the Committee had met daily and reviewed incident reports each day from the previous 24 hours, all investigations, all injuries of unknown origin, all allegations of misappropriation, and all other allegations. Further interview revealed the Committee was making the final decision on all investigations as to whether it was substantiated or not. Interview and review of the facility's Allegation of Compliance binder further revealed the Abuse Committee had been conducting five interviews daily with residents and staff regarding abuse and staff treatment of residents. Interview and review of the facility's Allegation of Compliance binder further revealed the facility was maintaining a log of all allegations and investigations to ensure they were initiated immediately. Interview further revealed the facility was utilizing the CQI tool for all allegations of abuse.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, and the QA Nurse at 2:07 PM revealed the QA team was meeting daily, Monday through Friday, and the CQI tool was being reviewed during the meeting.</p>	F 226			

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F 226	Continued From page 47 Policy review and interview with the DON on 05/07/14 at 3:45 PM revealed the facility's Abuse Policy and Procedure had been reviewed and revised. Interview on 05/07/14 with the DON at 3:45 PM revealed all information from the Abuse Committee and the QA Committee was given daily to the Administrator for his review. Policy review and interview on 05/07/14 at 3:45 PM with the DON revealed the following policy/procedures had been revised: resident Abuse Policy, QA Abuse Investigating Team, complaint of abuse form, form for reporting misappropriation of property, reporting protocol, check list of initial investigation, Nurse's instructions for initial allegations, initial allegation of abuse and neglect form, policy on resident protection during abuse investigation, reporting on injury of unknown origin policy, missing items monitoring form, initial investigation of misappropriation of property, policy on misappropriation of resident's property, and complaint/grievance report form.	F 226		
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	F 490	Please See Attachment	

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F 490	Continued From page 48 by: Based on interview, record review, and review of policy/procedures it was determined the facility's Administration failed to ensure its resources, including policies related to abuse and neglect, were used effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of four (4) sampled residents (Resident #7). Interviews and review of the incident report (undated) revealed on 01/22/14, Resident #7 informed Registered Nurse #2 that "four" days prior to the date of the interview (01/18/14), Certified Nurse Aide (CNA) #8 hurt the resident when he provided incontinence care to him/her. Interview revealed Resident #7 alleged Certified Nurse Aide (CNA) #8 "broke" his/her "vagina" and hurt her/his legs. CNA #8 and CNA #7, who were also in the room, informed Licensed Practical Nurse (LPN) #2 of the resident's complaints. However, the LPN failed to follow the facility's policies and procedures on receipt of the resident's allegation and failed to ensure an investigation was initiated, failed to ensure that residents were protected during the facility's investigation, and failed to inform the Administrator of the resident's allegation. On 01/22/14, Resident #7 reported the allegation to Registered Nurse (RN) #3, and RN #3 informed RN #2 (who was responsible for abuse investigations) of the allegation. RN #2 interviewed Resident #7 on 01/22/14 and notified the Director of Nursing (DON) of the resident's allegation. The DON informed RN #2 to not allow CNA #8 to provide care to Resident #7; however, the facility did not restrict CNA #8 from providing direct care to other residents in the facility. Interviews and record review revealed	F 490			

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F 490	<p>Continued From page 49</p> <p>Administration failed to ensure abuse policies and procedures were implemented. The facility failed to initiate an investigation of the allegation, failed to protect residents from further abuse, and failed to report the allegation of abuse immediately to State agencies when the allegation was reported to the LPN on 01/18/14 and the DON on 01/22/14. (Refer to F226 and F226.)</p> <p>The Administration's failure to ensure facility policies/procedures related to abuse prevention were implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents at the facility. Immediate Jeopardy was determined to exist on 01/18/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 483.75 Administration (F490) with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). The facility was notified of the Immediate Jeopardy on 04/24/14.</p> <p>A partial extended survey was conducted on 05/06-07/14. An acceptable Allegation of Compliance was received on 05/05/14 which alleged removal of the Immediate Jeopardy on 05/03/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/03/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F225 and F226.)</p> <p>The findings include:</p> <p>Review of the facility's policy, "Resident Abuse</p>	F 490			

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F 490	<p>Continued From page 50</p> <p>Policy," (not dated) revealed staff was to report all allegations of mistreatment, abuse, or misappropriation of resident property to the Administrator. According to the policy, the facility was to immediately report and thoroughly investigate all allegations of mistreatment, neglect, and abuse of residents, and allegations of misappropriation of resident property. The policy also revealed the Administrator, or his designee, would immediately notify the appropriate State agencies of the allegations. In addition, the policy revealed the facility would prevent further potential abuse during the investigation including the removal of alleged staff from the care of all residents.</p> <p>Interviews and record review revealed Resident #7 informed Certified Nurse Aide (CNA) #8 that he hurt the resident when he and CNA #7 provided incontinence care to the resident. CNA #7 and CNA #8 informed Licensed Practical Nurse (LPN) #2 of the resident's complaint when he and CNA #7 left the resident's room. However, LPN #2 failed to immediately report the allegation to the Administrator of the facility and/or State agencies, failed to initiate an investigation of the allegation, and failed to ensure residents were protected from further abuse during the course of an investigation. Although interview revealed Resident #7, LPN #2, CNA #8, and CNA #7 could not recall the exact date of the incident, interview on 04/24/14 at 5:50 PM with Registered Nurse (RN) #2 revealed she interviewed Resident #7 on 01/22/14 about the incident and the resident reported the incident occurred "four" days prior to the interview (01/18/14).</p> <p>Interview with RN #2 revealed she reported the abuse allegation to the Director of Nursing</p>	F 490			

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F 490	<p>Continued From page 51</p> <p>(DON). Interview with the DON on 04/24/14 at 5:05 PM revealed she advised staff that CNA #8 could continue to provide care to other facility residents, but the CNA would not be allowed to provide direct care to Resident #7. The DON stated she did not report the allegation to the Administrator of the facility and State agencies as required. In addition, the facility failed to take action to protect residents from further abuse/potential abuse until 04/24/14 (95 days after the incident) when the facility removed CNA #8 from direct patient care in the facility.</p> <p>Interview with the Administrator on 04/25/14 at 10:55 AM revealed he was not aware of the allegation of abuse by Resident #7 which occurred on 01/18/14 until 04/24/14. Further interview revealed LPN #2 "should" have informed "all of us" of the allegation made by Resident #7 at the time the resident reported the allegation.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 05/05/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The allegation of abuse from 01/18/14 was reopened on 04/25/14 with all regulatory agencies being notified. All staff members alleged to be present during the 01/18/14 allegation including State Registered Nurse Aide (SRNA) #8 and Licensod Practical Nurse (LPN) #2 were removed from the schedule and suspended pending the conclusion of this investigation.</p> <p>To ensure the safety of Resident #7, as well as all other residents residing at this facility, on 04/25/14 residents with a Brief Interview for</p>	F 490			

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F 490	<p>Continued From page 52</p> <p>Mental Status (BIMS) score of 8 and above were interviewed by the Activity/Social Services Director and/or Minimum Data Set (MDS) Coordinator to determine if any had failed to report an allegation of abuse, neglect, misappropriation, or exploitation. No reports of physical abuse were noted from these interviews. These interviews did identify 13 residents who reported missing items/money. Investigations were started immediately by members of the Abuse Committee. The appropriate State agencies were notified of these allegations on 04/28/14.</p> <p>Residents with a BIMS score below 8 had a head to toe skin assessment done on 04/25/14 by nurses. Ten residents were identified with bruises/areas of discoloration/scratches and scabs. These were reviewed by the Director of Nursing (DON) and Consulting Nurses on 04/27/14, and although none were of suspicious nature, investigations were started on 04/27/14 by the Quality Assurance (QA) Nurse and MDS Coordinators. The appropriate State agencies were notified on 04/28/14 by the MDS Coordinator. Investigations were concluded on 04/29/14 with all being unsubstantiated by the facility's QA Abuse Committee. On 05/01/14 and 05/02/14, the ten residents' investigations were reviewed again for possible causes of the injuries and what could be done to protect the resident from the reoccurrence of similar injuries.</p> <p>To ensure facility policy has been followed and the appropriate State agencies notified timely, members of the Abuse Committee, which are the DON, Social Services/Activity Director, MDS staff, QA Nurse, and Assistant Director of Nursing (ADON), reviewed on 05/01/14 all allegation</p>	F 490			

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F 490	<p>Continued From page 53</p> <p>reports from the year 2013 until present. The Abuse Committee reviewed daily all resident allegations, injuries of unknown origin, and any misappropriation of residents' property to ensure facility policy was followed and all notifications had been timely.</p> <p>All staff was interviewed by the ADON and the QA Nurse on 04/29/14 to determine if anyone had failed to report any allegations of abuse, neglect, misappropriation, or exploitation. There were no new allegations reported.</p> <p>The Nursing Home Administrator (NHA), DON, ADON, QA Nurse, Activity/Social Services Director, Resident Care Supervisor, MDS Coordinators, Medical Records Director, Data Compliance staff, and Office Assistant received in-service education by the Nurse Consultant on 04/25/14 regarding the regulatory requirements on reporting, investigation, and protection of residents with all allegations of abuse, neglect, misappropriation, and exploitation. On 05/01/14, additional in-service was provided by the Nurse Consultant on using the handouts provided at a seminar given by the Office of Inspector General on 02/26/14.</p> <p>Staff was in-serviced by the QA Nurse and/or the DON on April 25, April 26, April 27, and April 29, 2014 on the following items: investigating abuse, neglect, misappropriation, when to investigate, reporting abuse, neglect, misappropriation, collecting statements for investigations, performing head to toe assessments on residents when allegations are made to ensure the resident has no injury, notifying the Administrator, DON, ADON, and appropriate State agencies, when to call 911 for on-call Social Worker, resident's</p>	F 490			

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F 490	<p>Continued From page 54</p> <p>physician, and responsible party, protecting residents by removal of accused immediately, and removing resident(s) immediately out of harm's way.</p> <p>In-service was held on 05/01/14 with all LPNs, SRNAs, Certified Medication Technicians (CMTs), office staff, kitchen staff, housekeeping staff, laundry staff, maintenance staff, and janitorial staff attending. In-service was given by the DON. Two employees were not present at either meeting and those two employees were in-serviced on 05/02/14 by the DON. Information for the in-service included the training manual, "Hand In Hand: A Training Series for Nursing Homes." The in-service covered the following listed areas: revised abuse policy, revised investigation form, types of abuse, how to report abuse, protection of resident, preventing abuse, what constitutes abuse, LPNs starting investigation (what to do), allegations of abuse, identifying abuse, screening potential employees, and revised reporting protocol for abuse.</p> <p>A posttest was given on 05/01/14 to all staff after each of the in-services on examples related to abuse issues. The two employees in-serviced on 05/02/14 were given the posttest also. Employees who did not score 100 percent on their test were rein-serviced at the time the posttest was reviewed by the DON.</p> <p>As an ongoing training program, all new hires will be required to go through the abuse training that will include the following: screening, training, prevention, identification, investigation, protection, and reporting/response. Information for these trainings will be taken from the manual, "Hand in Hand: A Training Series for Nursing Homes."</p>	F 490		
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F 490	<p>Continued From page 55</p> <p>After these in-services, the new employee will be required to take a posttest to ensure they understand all issues related to abuse.</p> <p>In-services on abuse will be done monthly for a period of six months. The monthly abuse in-services will be conducted by either the DON or her designated staff member. Posttests will be done after each abuse in-service. All staff will be required to attend the monthly abuse in-services.</p> <p>Payroll Employee #1, the Office Manager, and Accounts Payable were in-serviced on the following revised policies and procedures by the ADON on 04/28/14: screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>Payroll Employee #1, the Office Manager, and Accounts Payable staff have reviewed all current employee files on the following to ensure current employees have no offences that would prevent them from working at this facility: Abuse Registry, Kentucky Court of Justice, local County Police Department, and the OIG Exclusion.</p> <p>The following policies and procedures have been revised by the DON and ADON: screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>The DON and Administrator have reviewed all employee files and signed off on them as of 04/29/14 indicating all current employees have no record that would prevent them from working at a long-term care facility.</p> <p>The facility QA team (DON, ADON, QA Nurse,</p>	F 490		

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F 490	<p>Continued From page 56</p> <p>MDS Coordinator, and Social Services/Activity Director) met with the Medical Director on 04/29/14 to review the circumstances of the allegation and all interventions which had been and will be implemented by the facility.</p> <p>The Administrator or his designee will be responsible for completing a thorough investigation of all allegations including the following: notifying appropriate State agencies timely, notifying residents' family and Physician timely, prevent further potential abuse, review the results of the investigation process and take any corrective action required such as retraining, disciplinary action, faxing information to agencies, and ensuring residents have been and are being protected.</p> <p>Members of the Abuse Committee will meet daily and review the following: all incident reports from the previous 24 hours, all investigations, all injuries of unknown origin, all allegations of misappropriation, and all other allegations.</p> <p>It will be the responsibility of the Abuse Committee to make the determination that an allegation is or is not substantiated.</p> <p>Members of the Abuse Committee will also be responsible for ensuring daily interviews are completed with five residents and five employees. Interviews were conducted with staff and residents seven days a week until the Immediate Jeopardy (IJ) was removed. Employee interviews were done on a random basis and included all shifts and all departments. After the IJ is removed, staff will continue to do staff and resident interviews weekly for six months to ensure all allegations are reported.</p>	F 490			

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F 490	<p>Continued From page 57</p> <p>A log will be maintained by the Abuse Committee to ensure five different residents and five different employees from different departments are interviewed daily. These interviews will be maintained in a log along with any allegations identified from the interviews. Investigations will be initiated immediately on any allegation identified from the interviews. All investigation information will also be maintained in the log. The information from these interviews will be reviewed daily by members of the Abuse Committee for any allegations and related investigations.</p> <p>It is the responsibility of the Abuse Committee to ensure all allegations are handled in a timely manner with all agencies being notified timely. The Continuous Quality Improvement (CQI) indicator for the monitoring of compliance with the components of the abuse regulation, including but not limited to investigating and reporting of abuse, will be utilized (during and at the conclusion of the investigation) with each allegation of abuse for four weeks, then monthly for four months, and then quarterly thereafter under the supervision of the Administrator and DON.</p> <p>Results of each abuse allegation CQI indicator will be reviewed by the QA team as part of the daily meetings, Monday through Friday, to ensure all allegations were handled correctly. The results of these CQI indicators will also serve as ongoing information to see where the facility's weak areas are with the seven components of abuse and neglect and in-services will be conducted related to these areas.</p> <p>Daily oversight related to the findings of the</p>	F 490			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2014
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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 490	<p>Continued From page 58</p> <p>completed CQI indicators will be reviewed by the contracted Nurse Consultant by e-mail to ensure all allegations are investigated and reported as indicated. Monthly visits to the facility will also be done by the Nurse Consultant.</p> <p>The facility's Abuse policies and procedures have been reviewed and revised by the DON, ADON, and Administrator.</p> <p>Information from the QA Committee and Abuse Committee will be given to the Administrator daily for his review. This information will include the following: all allegations of abuse, all abuse investigations and conclusions, QA findings, all allegations of misappropriation of property, all other allegations, and minutes from the QA Committee and Abuse Committee.</p> <p>It will be the Administrator's responsibility to oversee all aspects of this Allegation of Compliance.</p> <p>The following policies and procedures have been revised with most of the content being changed: resident Abuse Policy, QA Abuse Investigating Team, form for complaint of abuse, form for reporting misappropriation of property, reporting protocol, check list of initial investigation, Nurse's instructions for initial allegations, initial allegation of abuse and neglect form, policy on resident protection during abuse investigation, reporting on injury of unknown origin policy, missing items monitoring form, initial investigation of misappropriation of property, policy on misappropriation of resident's property, and complaint/grievance report form.</p> <p>**The surveyors validated the immediate</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 490	<p>Continued From page 59 Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interview with the DON on 05/07/14 at 3:45 PM verified the allegation of abuse by Resident #7 had been reopened and SRNA #8 and LPN #2 had been suspended during the investigation.</p> <p>Interview on 05/07/14 at 2:45 PM with the Activity/Social Services Director revealed all alert and oriented residents with a Brief Interview for Mental Status (BIMS) score of 8 and above had been interviewed regarding abuse and staff treatment and no concerns related to physical abuse or neglect were identified.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM and the Activity/Social Services Director at 2:45 PM revealed 13 residents had been identified during interview who reported missing money/items. Interview and review of the facility's Allegation of Compliance binder revealed the items/money had either been found or replaced and the appropriate State agencies had been notified.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 05/07/14 at 2:23 PM, and LPN #5 on 05/07/14 at 2:38 PM revealed they completed skin assessments on residents with BIMS scores below 8. Interview revealed some of the residents assessed had bruising/skin tears; however, none of the areas observed were of a suspicious nature.</p> <p>Interview on 05/07/14 at 3:45 PM with the DON and review of the facility's Allegation of Compliance binder revealed during the skin assessments any areas identified on a resident</p>	F 490			

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F 490	<p>Continued From page 60</p> <p>were reviewed by the DON and investigations were initiated, even though they were not of a suspicious nature. Further review revealed the appropriate State agencies had been notified.</p> <p>Interview on 05/07/14 at 3:45 PM with the Director of Nursing (DON), the Quality Assurance Nurse at 2:15 PM, the Assistant Director of Nursing (ADON) at 2:00 PM, and the Minimum Data Set (MDS) Nurse at 1:45 PM revealed they were a part of the Abuse Committee and had met daily and reviewed all allegations of abuse as a team. The Committee reviewed all allegations from the beginning of 2013 until present to ensure they had been investigated, protection had been provided, and they were reported timely to the appropriate agencies. Further, the Committee only identified a problem with one, which was reopened and investigated and no concerns were identified so it was unsubstantiated.</p> <p>Interview on 05/07/14 with LPN #4 at 2:43 PM, LPN #6 at 2:38 PM, SRNA #16 at 3:00 PM, and SRNA #15 at 3:10 PM revealed they had been interviewed regarding any abuse which may not have been reported. All staff interviewed denied any further knowledge of abuse.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM revealed they did receive in-service by the Nurse Consultant on 04/25/14 regarding regulatory requirements on reporting, investigation, and protection of residents with all allegations of abuse, neglect, misappropriation, and exploitation. Further interview revealed they also received in-service on 05/01/14 on using the</p>	F 490			

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F 490	<p>Continued From page 61</p> <p>handouts provided at a seminar by the Office of Inspector General.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 with the QA Nurse at 2:07 PM, the DON at 3:45 PM, LPN #4 at 2:43 PM, LPN #6 at 2:38 PM, SRNA #16 at 3:00 PM, and SRNA #15 at 3:10 PM revealed in-service was conducted for all staff regarding all components of abuse. Further interview with the LPNs, SRNAs, and the DON revealed another in-service was held on 05/01/14 using the training, "Hand In Hand: A Training Series for Nursing Homes." The staff stated they did take a posttest after the in-service.</p> <p>Interview with Payroll Employee #1 on 05/07/14 at 1:00 PM revealed the facility had not hired any new employees since 05/03/14.</p> <p>Review of the facility's Allegation of Compliance binder and interview with the ADON on 05/07/14 at 2:00 PM revealed Payroll Employee #1, the Office Manager, and Accounts Payable staff had been in-serviced regarding revised policies/procedures regarding screening of potential employees, criminal record background checks, and reference checks on potential employees.</p> <p>Review of the facility's Allegation of Compliance binder and interview on 05/07/14 at 1:50 PM with Payroll Employee #1 revealed all current employee files had been reviewed to ensure no current employee had an offence that would prevent them from working at a nursing facility.</p> <p>Interview with the DON on 05/07/14 at 3:45 PM and review of the following policy/procedures</p>	F 490			

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F 490	<p>Continued From page 62</p> <p>revealed they had been revised: screening of potential employees (revision date 04/25/14), criminal record background checks (revision date 04/25/14), and reference checks on potential employees (not dated).</p> <p>Interview with the DON on 05/07/14 at 3:45 PM revealed she and the Administrator had reviewed all current employee files.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM revealed the QA team had met with the Medical Director on 04/29/14 to ensure he was aware of the Immediate Jeopardy (IJ) and the interventions which had been put in place by the facility.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, the ADON at 2:00 PM, the QA Nurse at 2:07 PM, and the Activity/Social Services Director at 2:45 PM, who are members of the Abuse Committee, revealed the Committee had met daily and reviewed incident reports each day from the previous 24 hours, all investigations, all injuries of unknown origin, all allegations of misappropriation, and all other allegations. Further interview revealed the Committee was making the final decision on all investigations as to whether it was substantiated or not. Interview and review of the facility's Allegation of Compliance binder further revealed the Abuse Committee had been conducting five interviews daily with residents and staff regarding abuse and staff treatment of residents. Interview and review of the facility's Allegation of Compliance binder further revealed the facility was maintaining a log of all allegations and investigations to ensure they</p>	F 490			

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F 490	<p>Continued From page 63</p> <p>were initiated immediately. Interview further revealed the facility was utilizing the CQI tool for all allegations of abuse.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM, and the QA Nurse at 2:07 PM revealed the QA team was meeting daily, Monday through Friday, and the CQI tool was being reviewed during the meeting.</p> <p>Policy review and interview with the DON on 05/07/14 at 3:45 PM revealed the facility's Abuse Policy and Procedure had been reviewed and revised.</p> <p>Interview on 05/07/14 with the DON at 3:45 PM revealed all information from the Abuse Committee and the QA Committee was given daily to the Administrator for his review.</p> <p>Policy review and interview on 05/07/14 at 3:45 PM with the DON revealed the following policy/procedures had been revised: resident Abuse Policy, QA Abuse Investigating Team, complaint of abuse form, form for reporting misappropriation of property, reporting protocol, check list of initial investigation, Nurse's instructions for initial allegations, initial allegation of abuse and neglect form, policy on resident protection during abuse investigation, reporting on injury of unknown origin policy, missing items monitoring form, initial investigation of misappropriation of property, policy on misappropriation of resident's property, and complaint/grievance report form.</p>	F 490			

Hicks Golden Years Nursing Home

F166

483.10 Please accept our credible allegation of compliance.

(Right to prompt efforts to resolve grievances)

Staff has been in serviced on answering residents #4, #5, & #6 call lights immediately with the time not to exceed five (5) minutes.

Residents #4, #5, & #6 will be monitored weekly for 6 weeks by means of an interview on call lights to ensure they are being answered timely. (See attachment #1)

Residents #4, #5, & # 6 interviews will be reviewed weekly for 6 weeks by the Abuse Committee with any problems identified being investigated.

Call light interviews will be done weekly for a period of 6 months with a random selection of residents to ensure all call lights are answered immediately with a time frame not to exceed five (5) minutes.

After the 6 month time frame of call light interviews being completed weekly the interviews will be conducted monthly to ensure no problem recurs with the answering of call lights being answered immediately with the time frame not to exceed five (5) minutes.

Monthly call light interviews will be reviewed by the Abuse Committee after completed with identified problems investigated.

Residents with a BIMS score of 8 or above have been interviewed by the Activities/SS Director to ensure their call lights are being answered in a timely manner. (See attachment #1)

In services have been held with staff on answering call lights in a timely manner (not to exceed 5 minutes) by the following staff on the following dates:

1. 4-28-14 10:15am Debbie Tucker DON
2. 5-21-14 1:00pm Amy Huff QA
3. 5-27-14 6:40pm Jennifer Arms LPN
4. 6-2-14 11:00pm Lisa Linder LPN
5. 6-3-14 9:30am Debbie Tucker DON
6. 6-4-14 9:00pm Cindi Smith LPN
7. 6-5-14 10:00am Debbie Tucker DON

Weekly audits are being conducted by the Director of Nursing &/or her designee on the timing of call lights to monitor how long it takes staff to answer them. (See attachment #2)

Weekly call light audit will be monitored for a period of 6 months. Weekly call light audits will be reviewed by the Abuse Committee with appropriate interventions implemented.

Problems identified by the weekly call light audits will be investigated by the Abuse Committee.

Policies & procedures on call lights have been reviewed and revised by the Director of Nursing. (See attachment #3)

A minimum of 5 residents with a BIMS score of 8 or above will be interviewed weekly by the Activities/SS Director &/or her designee to ensure call lights are being answered in a timely manner (not to exceed 5 minutes).

Resident interviews related to answering of call lights will be reviewed by the abuse committee weekly.

Quality Assurance will monitor call lights monthly to ensure staff continues to answer them in a timely manner.

Staff who sits in on Resident Council Meetings has been serviced on completing the necessary forms & of notifying the necessary staff on complaints/grievances voiced at resident council meetings.

Resident Council Minutes have been reviewed for the past 5 months to ensure all complaints/grievances have been addressed.

Procedure for reporting complaints/grievances were reviewed & revised on 6-6-14. (See attachment # 5)

New forms have been implemented to ensure all grievances/complaints voiced at the resident council meeting has been reported to the DON, Administrator, & Abuse Committee, investigated, & reported back to the residents on what is being done to resolve the stated issues.

1. Resident Council Policy (See attachment #6)
2. Resident Council Meeting (See attachment #7)
3. Resident Council Minutes (See attachment #8)
4. Complaint/Grievance Report (See attachment #9)
5. Reporting Grievances, Concerns & Incidents (See attachment #10)
6. Abuse Investigation and Reporting (See attachment #39)
7. Allegation of Abuse/Neglect Checklist (See attachment #40)

Quality Assurance will monitor monthly resident council minutes for complaints/grievances to ensure they have been reported, investigated, acted on, & a report given to the residents in a timely manner on all issues voiced. (See attachment #11)
Quality Assurance will monitor monthly the weekly call light audits to ensure call lights are being answered correctly.

Completion Date: 6-12-2014

#1

Interview for Call Lights

Resident _____ Date: _____

Staff Signature: _____

- 1) Is staff answering your call light in a timely manner? ____ Yes ____ No
If resident answers no have him/her explain in detail:

- 2) How long does it take staff to answer your call light? _____

- 3) Has staff improved in answering your call light timely? ____ Yes ____ No
Explain no answer in detail:

- 4) Is certain days or times worse for your call bell to be answered timely? _____

Date Director of Nursing reviewed interview results: _____

Comments:

DON Signature Date

Administrator's Signature Date

#2

CALL LIGHT AUDIT TOOL

	Date	Room Number	Call Light in Reach?	Call Time	Answer Time	Total Minutes	Answered By (title):	Comments
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Completed By: _____

Month/Year: _____

ACTION PLAN

Problem	Corrective Action	Target Date / Responsible Party

Administrator's Signature _____

Director of Nursing Signature _____

#3

Policy and Procedure
Call Light

1. It is the responsibility of all Nurses, Med Techs and SRNAs to ensure call lights are answered promptly. All staff except dietary are also responsible to help with the answering of call lights and then to get someone to help the resident with what ever they are needing at the time.
 2. Call lights are to be answered immediately with the time frame of answering call lights by staff not to exceed five (5) minutes.
 3. Call lights will be monitored regular intervals and at various times to ensure they are being answered promptly.
 4. If there is a light not working, it is to be reported immediately to the Maintenance Department. If there light has to be worked on, then the resident will be placed where they have access to a call light.
 5. Quality Assurance will track and trend to see if there is any type of patterns with rooms, residents or employees.
-

Revised 6-9-2014

#5

Procedure for Complaints/Grievances

- 1) Report complaints, grievances to the charge nurse immediately.
- 2) The charge nurse, Act/SS Director &/or designee will be responsible for starting an investigation into the complaint/grievance immediately..
- 3) Charge nurse completes Section 1 of the Complaint/Grievance report & contacts the Administrator & DON.
- 4) During week days the Act/ SS Director or his/her designee will be responsible for starting an investigation into the complaint/grievance & completing section 2 of the report.
- 5) On weekends it will be the responsibility of the charge nurse to start investigations into complaints/grievances and complete section 2 of the report.
- 6) On weekends it will be the responsibility of the charge nurse to notify appropriate staff of complaints/grievances as indicated.
- 7) Findings of the investigation will be documented on the complaint/grievance report.
- 8) A plan of action to resolve the issue or problem will be discussed by the Abuse Committee & placed into action.
- 9) Investigations will be completed within 48 hours of the complaint/grievance.
- 10) The complaint will be notified of the investigation findings with in 24 hours of the completion of the investigation by the Abuse Committee designee.
- 11) Act/SS Director &/or their designee will be responsible to report the findings of the investigation & what is being done or was done to resolve the problem.
- 12) Documentation will include who notified the resident, family member, findings of investigation, what is being done to resolve the problem & the date, time of the notification.

Revised 6-9-2014

#6

Resident Council Policy

- 1) Resident council meeting will be held monthly.
- 2) Minutes will be kept of each meeting.
- 3) It will be the responsibility of the Activities/SS Director &/or her designee to report all complaints &/or grievances voiced at the resident council meeting to the DON and Administrator in writing.
- 4) Residents with a BIMS score of 8 or above will be invited to attend meeting.
- 5) Family members of residents with a BIMS score of 7 & below will be allowed to attend the meeting if desired to voice any concerns they may have.
- 6) A resident with a BIMS score of 8 or above will serve as the president of the council.

Revised 6-9-2014

#4

Resident Council Meeting

Grievances/Complaints

Date: _____ Time: _____

Complaints/grievances voiced during resident council meeting:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Date complaints/grievances reported to Director of Nursing: _____

Date complaints/grievances reported to Administrator: _____

Date complaints/grievances reported to Abuse Committee: _____

Resolution to complaints/grievances:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Date resolution to complaints/grievances reported to residents: _____

Staff Signature: _____

Complaint / Grievance Report

#9

Section I

Date: _____

Time: _____

Complaint/Grievance: (describe in detail)

Reported By: _____

Reported To: _____

This section completed by: _____

Section II

Documentation of investigation:

Date investigation started: _____

Individual responsible for investigation: _____

Findings of investigation:

Plan of action to resolve issue:

D.O.N signature: _____

Administrators signature: _____

10

Reporting Grievances, Concerns & Incidents

Residents, their responsible parties, family members & employees may voice concerns relating to any grievance or incident without discrimination or reprisal from the facility. Residents, responsible parties, or family members may report their concerns or grievances to any employee. Employees who receive concerns or grievances from a resident, responsible party or family member should immediately report it to the charge nurse & write a statement that includes what the concern, grievance was who reported it to them & sign & date the report. Employees are to report their concerns to their immediate supervisor. The supervisor is responsible for directing the concern or grievance to the correct people. It will be the charge nurses responsible to complete a grievance form if the social service individual is not present.

Revised 4-28-2014

#39

Indicator: Abuse Investigation and Reporting

Threshold: 100%

Directions: Members of the quality improvement team will review resident medical records, investigation reports, other internal reports and perform staff interviews as needed to complete the appropriate section of this form. Mark 'X' for a YES response, 'O' for a NO response, and 'N/A' if not applicable. A NO response may indicate a potential problem.

Criteria/Question Mark 'X' for YES, 'O' for NO, or 'N/A'	Resident				
	1	2	3	4	5
Resident to Resident Altercation/Abuse:					
1. The staff member(s) suspecting abuse immediately reported the alleged incident to their supervisor and/or the Administrator (or designee).					
2. The residents were separated from each other immediately to assure their safety.					
3. A thorough examination of both residents was conducted for any suspicious marks, bruising, injury, or indication of change in emotional/mood status and is documented.					
4. An investigation was performed (as defined per policy).					
5. If abuse, neglect, exploitation or misappropriation was alleged, then the Office of the Inspector General (OIG), Dept. of Community Based Services (DCBS) and other state/local agencies were notified.					
6. The resident's attending physician and legal representative were notified of the incident and any suspicious marks, bruising, injury or indication of change in emotional/mood status found during the examination.					
7. An evaluation of the aggressive resident was completed to determine if there was a problem requiring medical intervention to prevent further incidents.					
8. The aggressive resident had an assessment, care plan and behavior management program in place to prevent conflict/aggression.					
9. The above has been reviewed and revised as needed and all new approaches are re-evaluated for effectiveness by an interdisciplinary team per policy.					
Alleged abuse by a staff member:					
10. The staff member(s) suspecting abuse immediately reported the alleged incident to their supervisor and Administrator (and/or designee).					
11. The resident's safety and protection was assured					

#39

Criteria/Question Mark 'X' for YES, 'O' for NO, or 'N/A'	Resident				
	1	2	3	4	5
by the immediate suspension/physical removal of the employee involved.					
12. The allegation of abuse, neglect, exploitation or misappropriation was immediately reported to the OIG, DCBS, and other state/local agencies as required and is documented, (date, time and person reported to).					
13. A thorough examination of the resident was conducted for any suspicious marks, bruising, injury or change in emotional/mood status and is documented.					
14. The Administrator or designee immediately began a thorough investigation of the alleged incident of abuse, neglect, exploitation or misappropriation.					
15. The resident's attending physician and legal representative were notified of the alleged abuse incident and any suspicious marks, bruising, injury or change in emotional/mood status found during the examination.					
16. The employee(s) suspected of the alleged abuse has the following forms in their employee file: <ul style="list-style-type: none"> • Reference check from previous employer(s) • State Abuse Registry, Sex Offender Registry and the OIG Exclusion Check • Criminal record check showing no felony's or misdemeanors related to abuse, neglect, or exploitation of an adult • Signed acknowledgment of the corporate Abuse Policy 					
17. The Administrator completed the investigation and sent a copy of it to the OIG within 5 working days of the alleged incident.					
18. The attending physician and the resident's legal representative were notified of the results of the investigation.					
19. Any subsequent knowledge of actions by a court of law against an employee, which would indicate unfitness for service, is reported to the Nurse Aide Abuse Registry by the Administrator.					
Alleged Abuse by an Individual not Directly Associated with the Facility:					
20. The staff member(s) suspecting abuse, neglect, exploitation or misappropriation immediately reported the alleged incident to their supervisor and Administrator (and/or designee).					

#39

Criteria/Question Mark 'X' for YES, 'O' for NO, or 'N/A'	Resident				
	1	2	3	4	5
21. The alleged abusive person was removed from the facility and not allowed to return until the facility internal investigation is complete.					
22. The incident was immediately reported to the OIG, DCBS and other state/local agencies as required					
23. A thorough examination of the resident was conducted for any suspicious marks, bruising injury or change in emotional/mood status and is documented.					
24. The Administrator or designee immediately began a thorough investigation of the alleged incident of abuse, neglect, exploitation or misappropriation.					
25. The resident's attending physician and legal representative were notified of the incident and any suspicious marks, bruising, injury or change in emotional/mood status found during the examination.					
26. The attending physician and the resident's legal representative were notified of the results of the investigation.					
Other issues:					
27. Bruises and/or other injuries are investigated to determine that the cause is not of unknown origin. Injuries of unknown origin are reported to the state/local agencies as required.					
28. Missing items that are unable to be located upon immediate search of the facility, will be reported and investigated as allegations of potential misappropriation of property and reported to state/local agencies as required.					
29.					
30.					

Percentage of compliance = $\frac{\# \text{ Yes responses}}{\text{total \# of responses}} \times 100$ %Compliance: _____

Threshold met: Yes No Plan of correction implemented: Yes No

Date completed: _____ By: _____

Rev: 1/12

Privileged and Confidential – for Quality and Peer Review Only