

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/23/2013
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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N 018	Continued From page 1	N 018		
N 018	902 KAR 20:300-3(2)(i)1.b. Section 3. Resident Rights	N 018	SEE ATTACHED 9/16/13	
	<p>(2) Notice of rights and services.</p> <p>(i) Notification of changes.</p> <p>1. Except in a medical emergency or when a resident is incompetent, a facility shall consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is:</p> <p>b. A significant change in the resident's physical, mental, or psychosocial status;</p> <p>This requirement is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure the Physician was immediately notified of an incident which required transfer to an acute care facility for emergency treatment for one (1) of nine (9) sampled residents (Resident #1). Additionally, the facility failed to immediately notify the Legal Representative for Resident #1 when an incident occurred that required Physician intervention. On 08/03/13 at 4:30 AM, Resident #2 was found in Resident #1's room with the door closed. Interview revealed Resident #1 was found in a fetal position on his/her side with the pajama pants and adult brief pulled down below the buttocks and the buttocks were exposed. A wet substance was found on Resident #1's buttocks, blanket, and on the outside of the adult brief. Interview revealed Resident #2 was sitting in his wheelchair with the zipper of his/her pants down. Interview and record review revealed the facility failed to immediately notify Resident #1's Physician and/or Legal Representative of the</p>			

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N 018	<p>Continued From page 2</p> <p>incident.</p> <p>The facility's failure to ensure an effective system was in place to ensure the Physician and Legal Representative were immediately notified of an potential incident of sexual abuse presents an imminent danger to residents creates substantial risk that death or serious mental or physical harm will occur. The Imminent Danger was identified on 08/15/13, and determined to exist on 08/03/13. The facility was notified of the Imminent Danger on 08/15/13.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Accidents and Incidents" undated, revealed regardless of how minor an accident or incident may be, it must be reported to the department supervisor, and an Accident/Incident Report Form must be completed on the shift that the accident or incident occurred with the time the resident's attending Physician was notified as well as the date and time the resident's Legal Representative was notified and by whom.</p> <p>Review of the facility's policy titled, "Physician Notification Policy/Procedure" revised 08/07, revealed the Physician should be notified within twenty-four (24) hours except in medical emergencies. Review of the facility's policy titled, "Family Notification Policy/Procedure" undated, revealed the resident's Legal Representative should be notified within twenty-four (24) hours except in emergencies.</p> <p>Record review revealed Resident #1 was admitted to the facility on 05/10/12 with the diagnoses which included Mental Retardation, Scoliosis, and Anemia. Review of the Nursing</p>	N 018		
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N 018	<p>Continued From page 3</p> <p>Notes, dated 08/03/13 at 4:00 AM, revealed staff entered the resident's room and found another resident in his/her room.</p> <p>Review of the resident's physician orders revealed on 08/03/13 at 11:00 PM, an order was received from Resident #1's physician to transport Resident #1 to the emergency department for evaluation; approximately eighteen and a half (18 1/2) hours after the incident.</p> <p>Review of the Social Service Notes, dated 08/04/13 at 12:30 AM, revealed the resident's Legal Guardian/Mother was informed of Resident #1's transfer to an Emergency Department for an evaluation and labs; approximately twenty (20) hours after the incident.</p> <p>Review of the Emergency Department notes, dated 08/04/13 at 1:05 AM, revealed Resident #1 presented to the emergency department for a possible sexual assault. Continued review revealed, a sexual assault evidence collection examination was completed and the results were not available at the time of the survey.</p> <p>Interview on 08/15/13 at 7:06 PM, with Licensed Practical Nurse (LPN) #5 who was Resident #1's primary nurse and charge nurse, revealed she found Resident #2 in Resident #1's room with the door closed. Further interview revealed Resident #1's left hip and buttocks were exposed and the blanket had wet spots on it. LPN #5 stated she notified her Manager On Duty who notified the Corporate Executive Officer (CEO) who called her for further information. LPN #5 stated she was not directed to notify the Physician or family and for non-emergencies the policy was to notify within twenty-four (24) hours. Further interview</p>	N 018		
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N 018 Continued From page 4

revealed she did not think anything had happened because Resident #2 could walk but he was in a wheel chair, Resident #1 had a fall mat beside his/her bed, Resident #2 could not remove his/her own pants, was not in the room but maybe five (5) or ten (10) minutes and did not have enough time. Continued interview revealed Resident #2 could have gotten out of his/her wheel chair touched Resident #1 inappropriately and gotten back into his/her wheel chair.

Interview with the Assistant Administrator who was also Social Services Designee (SSD), on 08/21/13 at 10:44 AM, revealed she was notified of the incident on 08/03/13 at approximately 9:30 AM. Further interview revealed she did not follow the facility's policy for notification because she did not think anything had happened.

Interview with the CEO, on 08/21/13 at 12:33 PM, revealed the Physician and family should have been notified per the facility's policy.

Interview with the Administrator, on 08/21/13 at 2:42 PM, revealed the Physician and family should have been notified when the incident occurred.

Interview with Resident #1's legal guardian, on 08/21/13 at 1:58 PM, revealed she was notified by the SSD on 08/04/13 at 1:46 AM of Resident #1's transfer to the emergency department. Continued interview revealed she was advised the staff had found a resident of the opposite sex in Resident #1's room and the facility was transferring Resident #1 to the emergency department for his/her safety just to obtain a few swabs but that the facility was one hundred (100%) percent certain nothing had happened. Continued interview revealed the legal guardian

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was again notified by the SSD, after Resident #1 returned from the emergency department, and she was advised all examinations and labs were negative and that no sexual assault had occurred. However, evidence from the sexual assault collection examination had not been processed at the time of the State Survey Agency's investigation, concluding on 08/23/13.

The State Survey Agency was unable to obtain an interview with Resident #1's physician due to his death on 08/05/13.

Interview with Resident #2's Physician and the Physician that assumed Resident #1's care, on 08/14/13 at 8:36 PM, revealed his expectation would be for the staff to notify him and family members for resident behaviors.

N 018

N 039 902 KAR 20:300-3(5)(a) Section 3. Resident Rights

(5) Privacy and confidentiality of personal and clinical records.
(a) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room;
This requirement is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure privacy was provided during personal care (bathing) for one (1) of three (3) shower rooms. The facility failed to provide privacy curtains for the shower in the 300 hall shower room.

N 039

SEE ATTACHED 9/16/13

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N 039	Continued From page 6 The findings include: Review of the facility's policy titled, "Resident Rights" undated, revealed residents have a right to privacy during personal care. Observation of the 300 hall shower room, on 08/14/13 at 7:54 PM, revealed the door to be unlocked and accessible to all staff, residents and visitors with no locking mechanism on the door. Further observation revealed the shower room to have a toilet, bathing tub, sink and shower area with no privacy curtain to maintain privacy to the residents during bathing. Interview with Certified Nursing Aide (CNA) #1, on 08/14/13 at 7:54 PM, revealed the shower room was used for showering residents and she did not remember when the privacy curtain was removed. Further interview revealed the shower room could be accessed by staff, residents and visitors during a resident's shower and this would be a dignity and privacy issue. Interview with the Director of Nursing, on 08/22/13 at 5:14 PM, revealed she was not aware the privacy curtain was missing. Further interview revealed there should be a privacy curtain to maintain the resident's privacy and dignity.	N 039		
N 104	902 KAR 20:300-5(2) Section 5. Resident Behavior & Fac. Practice (2) Abuse. The resident shall have the right to be free from verbal sexual, physical or mental abuse, corporal punishment, and involuntary seclusion.	N 104	SEE ATTACHED 9/16/13	

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N 104

This requirement is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure each resident remained free from abuse. The facility failed to protect one (1) of nine (9) sampled residents from abuse (Resident #1). On 08/03/13 at 4:00 AM, Resident #2 was found in Resident #1's room with the door closed. Interview revealed Resident #1 was found in a fetal position on his/her side with the pajama pants and adult brief pulled down below the buttocks and the buttocks were exposed. A wet substance was found on Resident #1's buttocks, blanket, and on the outside of the adult brief. Interview revealed Resident #2 was sitting in his wheelchair with the zipper of his/her pants down.

Interview and record review revealed Resident #1 was not assessed for injury, nor was the resident's Physician or Legal Representative immediately notified of the incident.

Interview and record review revealed the facility failed to investigate the incident and report the incident to the appropriate State Agencies.

Interview also revealed Resident #2 had a history of exhibiting inappropriate touching of Resident #1. Record review revealed Resident #2 would stare into other residents' rooms, cuss in the hallways, and make sexual comments; however, there was no documented evidence the facility had addressed Resident #2's behavior.

The facility's failure to ensure an effective system was in place to ensure each resident remained

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N 104	<p>Continued From page 8</p> <p>free from abuse, presents and imminent danger and creates a substantial risk that death or serious mental or physical harm will occur. The Imminent Danger was identified on 08/15/13, and determined to exist on 08/03/13. The facility was notified of the Imminent Danger on 08/15/13.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse Reporting" undated, revealed the facility will not condone resident abuse by anyone, including staff members legal guardians, sponsors, friends, or other individuals. Further review revealed the definitions of abuse were provided to assist staff members in recognizing incidents of abuse. Further review revealed sexual abuse defined as, but not limited to, sexual harassment, sexual coercion, or sexual assault. Continued review of the facility's policy revealed, upon receiving a report of suspected abuse, the charge nurse shall examine and interview the resident with findings of the examination recorded in the resident's medical record. Further review revealed when sexual abuse is suspected, the resident is not to be bathed and clothing or linens should not be washed. Further review revealed the charge nurse should complete an incident form, notify the resident's physician, responsible party, and the administrator or designee.</p> <p>Review of the facility's policy titled, "Resident Rights" undated, revealed residents have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.</p> <p>Record review revealed Resident #1 was admitted to the facility on 05/10/12 with diagnoses which included Mental Retardation, Scoliosis, and</p>	N 104		
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N 104	<p>Continued From page 9</p> <p>Anemia. Review of the Quarterly Minimum Data Set (MDS) dated 07/22/13, revealed the facility assessed Resident #1 to be unable to complete a Brief Interview for Mental Status (BIMS) and to be severely cognitively impaired.</p> <p>Record review revealed Resident #2 was admitted to the facility on 02/12/13 with diagnoses which include Altered Mental Status, Seizure Disorder, Obstructive Hydrocephalus, Schizophrenia, Degenerative Joint Disease, and Mental Retardation. Review of Quarterly Minimum Data Set (MDS), dated 05/14/13, revealed the facility assessed Resident #2 with a Brief Interview for Mental Status (BIMS) summary score of 11/15, indicating the resident was moderately impaired in cognition.</p> <p>Review of the Nursing Notes, dated 08/03/13 at 4:00 AM, revealed staff entered the closed door to Resident #1's room and found Resident #2 in his/her room with the resident.</p> <p>Interview with Resident #1's primary nurse and charge nurse, Licensed Practical Nurse (LPN) #5, on 08/15/13 at 7:06 PM, revealed she found Resident #2 in Resident #1's room with the door closed. Further interview revealed Resident #1's left hip and buttocks were exposed and the blanket had wet spots on it. LPN #5 stated she had seen Resident #2 approximately five (5) or ten (10) minutes prior to the event. LPN #5 stated upon finding Resident #2 in Resident #1's room, she notified her Manager On Duty (MOD) who notified the Corporate Executive Officer (CEO) who called her for further information.</p> <p>Interview with Certified Nursing Aide (CNA) #3, on 08/20/13 at 10:05 AM, revealed she entered Resident #1's room immediately behind LPN #5.</p>	N 104		
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N 104	<p>Continued From page 10</p> <p>CNA #3 stated LPN #5 went to Resident #2 and she went to Resident #1. LPN #5 removed Resident #2 from Resident #1's room. Further interview revealed CNA #3 found Resident #1 lying on his/her right side in a fetal position with his/her pajama pants and adult brief pulled down under the buttocks with his/her buttocks completely exposed. Further interview revealed Resident #1 was found to have a wet substance on his/her hip, on the outer side of his/her adult brief, and on the resident's blanket. CNA #3 reported she stayed with Resident #1 briefly until CNA #2 bathed Resident #1. Continued interview revealed CNA #3 reported to LPN #5 that Resident #1's pajama pants and adult brief were pulled down and a wet substance was found on Resident #3's hip, on the outside of his/her brief, and on the blanket.</p> <p>Interview with LPN #2, on 08/14/13 at 6:53 PM, revealed she was the third person into the room and Resident #1 was lying on his/her right side in the fetal position with his/her pajama pants and adult brief pulled down under the buttocks exposing Resident #1's buttocks. Further interview revealed she did not think Resident #1 was capable of pulling his/her own pajama pants and adult briefs down. LPN #2 stated Resident #1 did not appear to be in distress. Resident #1 was facing the wall with his/her eyes closed. LPN #2 stated she then went back to care for her assigned residents. Further interview with LPN #2, on 08/14/13 at 8:25 PM, revealed CNA #2 asked LPN #2 if she should bathe Resident #1. LPN #2 told CNA #2 to bathe Resident #1 because "I would want a bath if it happened to me", I would feel dirty".</p> <p>Interview with CNA #2, on 05/15/13 at 7:47 PM, revealed she was on duty the night of 08/03/13.</p>	N 104		
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N 104	Continued From page 11 CNA #2 stated she was in Resident #1's room immediately after Resident #2 was removed. Further interview revealed Resident #1's pajama pants and adult brief were pulled down below Resident #1's buttocks. Further interview revealed CNA #2 pulled Resident #1's adult brief up. Continued interview revealed a wet substance was found on Resident #1's blanket, hip and outer surface of the adult brief. Continued interview revealed she asked LPN #2 if she should bathe Resident #1. Further interview revealed Resident #1 was bathed because Resident #2 could have sexually assaulted Resident #1. CNA #2 stated if this happened to her she would want someone to bathe her because she would feel dirty. CNA #2 stated she was not aware that she should not have bathed Resident #1. Interview with CNA #1, on 08/14/13 at 7:54 PM, revealed she was the CNA that monitored Resident #2 immediately after LPN #5 removed the resident from the room. Further interview revealed Resident #2's zipper of his/her pants was down when the resident was found in the room. Interview with a State Police Detective on 08/16/13 at 2:30 PM revealed the State Police responded to the facility the evening of 08/03/13 after receiving an anonymous call to report an allegation of sexual assault. Continued interview revealed the Police Officers found no documented evidence related to the allegation, and no documented evidence Resident #1 had been evaluated by a physician. Further interview revealed during the process of the Police investigation the State Police requested the sexual assault examination.	N 104		
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N 104	<p>Continued From page 12</p> <p>Further review of Resident #1's Nursing Notes revealed on 08/04/13 at 12:30 AM, Resident #1 was transferred to the emergency department for evaluation and labs, approximately twenty (20) hours after staff was aware of the incident.</p> <p>Review of the Emergency Department notes, dated 08/04/13 at 1:05 AM, revealed Resident #1 presented to the Emergency Department for a possible sexual assault. Continued review revealed a sexual assault evidence collection examination was completed. The emergency Physician noted the nursing facility staff had bathed Resident #1 and changed and washed Resident #1's clothing and linens prior to seeking emergency care. Evidence from the sexual assault collection examination had not been processed at the time of the State Survey Agency's investigation.</p> <p>Interview with the Manager of Duty (MOD), on 08/16/13 at 3:34 PM, revealed she was notified by LPN #5 on 08/03/13 at approximately 4:30 AM of an incident involving Resident #2 being found in Resident #1's room with the door closed. Further interview revealed LPN #5 told her Resident #1's adult brief had been pulled down exposing his/her buttocks and the adult brief and linens had a wet sticky substance on them. The MOD stated she reported the information she received from LPN #5 to the CEO and also reported the staff were very upset. The MOD stated she was advised by the CEO that she (the CEO) would call LPN #5.</p> <p>Interview with the Corporate Executive Officer (CEO), on 08/14/13 at 8:55 PM, revealed she was advised of the incident on 08/03/13 at approximately 4:45 AM. Further interview revealed she was advised Resident #1 was found</p>	N 104		
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N 104: Continued From page 13

with his/her pajama pants and adult brief pulled down exposing Resident #1's buttocks and a wet substance was found on Resident #1's blanket. However, the CEO stated she did not think anything had happened.

Interview with the Owner of the facility, on 08/15/13 at 2:01 PM, revealed the incident of 08/03/13 was just "gossip" from a staff member that was now afraid for his/her job. The Owner stated Resident #2 was "just a wandering resident", she (the owner) was "one hundred (100%) percent certain, no way" a sexual assault happened. Further interview revealed "people were assuming the worst" and stated there was no evidence an altercation or anything had occurred.

Interview with two resident(s), whom the facility had assessed as being interviewable, revealed Resident #2 had a history of exhibiting inappropriate touching/behavior towards Resident #1.

Interview with Resident #4, on 08/16/13 at 12:59 PM, revealed Resident #4 had witnessed Resident #2 put his/her hand between Resident #1's legs. Continued interview revealed, Resident #4 advised staff to "keep an eye on" Resident #2 and keep him/her out of Resident #1's room. Further interview revealed Resident #4 did report his/her concerns to the Assistant Administrator/Social Services Designee.

Interview with Resident #5, on 08/16/13 at 1:10 PM, revealed Resident #5 recalled specific incidents when Resident #2 would reach towards Resident #1's breast and Resident #5 would intervene prior to any actual touching. Resident #5 stated the residents had to look out for

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N 104	Continued From page 14 Resident #1 and keep Resident #2 away from Resident #1. Interview with the Assistant Administrator/Social Service Director (AA/SSD), on 08/21/13 at 10:44 AM, revealed she was not aware of Resident #2 making sexually inappropriate comments gestures or touching others.	N 104		
N 105	902 KAR 20:300-5(3) Section 5. Resident Behavior & Fac. Practice (3) Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents. This requirement is not met as evidenced by: Based on interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system to ensure policy and procedures were implemented related to abuse for one (1) of nine (9) sampled residents (Resident #1). On 08/03/13 at 4:00 AM, Resident #2 was found in Resident #1's room with the door closed. Interview revealed Resident #1 was found in a fetal position on his/her side with the pajama pants and adult brief pulled down below the buttocks and the buttocks were exposed. A wet substance was found on Resident #1's buttocks, blanket, and on the outside of the adult brief. Interview revealed Resident #2 was sitting in his wheelchair with the zipper of his/her pants down. There was no documented evidence the	N 105	SEE ATTACHED 9/16/13	

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N 105	<p>Continued From page 15</p> <p>facility assessed the resident for injury, conducted an investigation, or reported the incident to the appropriate State Agencies per the facility's policy and procedures.</p> <p>Based on the above findings, it was determined the facility's failure to implement it's abuse policy and procedures presents an imminent danger and creates substantial risk that death or serious mental or physical harm will occur. Imminent Danger was identified on 08/15/13 and was determined to exist on 08/03/13.</p> <p>The findings include:</p> <ul style="list-style-type: none"> Review of the facility's policy titled, "Abuse Reporting" undated, revealed each person observing an incident of resident abuse or suspected resident abuse should immediately report the incident to the charge nurse. The charge nurse should complete an Incident Report Form and should examine and interview the resident and report all findings to the Administrator or designee. The policy stated if sexual abuse was suspected, DO NOT bathe the resident or wash the resident's clothes or linen. Further review revealed upon receiving suspected reports of abuse, misappropriation of property, or neglect, the Administrator or designee should report the incident to the appropriate authorities. Review of the facility's policy titled, "Abuse Investigation" undated, revealed all personnel were to promptly report any incident or suspected incident of resident abuse. Further review revealed when an incident or suspected incident of abuse is reported, the investigation should begin immediately. Continued review revealed the investigation should consist of the review of the 	N 105		
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N 105	<p>Continued From page 16</p> <p>completed incident report form; a review of the statement of the person reporting the incident; a review of the statements of any witnesses; an interview with the resident; a review of the resident's medical record; an interview with the resident's roommate; and, a review of all circumstances surrounding the incident.</p> <p>Review of Resident #1's Nursing Notes, dated 08/03/13 at 4:00 AM, revealed staff entered the closed door to Resident #1's room and found Resident #2 in his/her room with the resident.</p> <p>Staff interviews revealed Resident #1 was found lying on his/her right side in a fetal position with his/her pajama pants and adult brief pulled down under the buttocks with his/her buttocks completely exposed. There was a wet substance on his/her hip, on the outer side of his/her adult brief, and on the resident's blanket. However, record review revealed no documented evidence the resident was assessed for injury, an incident report was completed, an investigation of the incident was completed, or the appropriate State Agencies were notified per the facility's policies.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 08/15/13 at 7:06 PM, revealed LPN #5 found Resident #2 in Resident #1's room and notified the Manager On Duty. Per interview she did not assess Resident #1 for any injuries related to the incident. LPN #5 stated LPN #2 assessed Resident #1. However, LPN #5 stated LPN #2's assessment of Resident #1 was he/she did not appear to be in distress and had his/her eyes closed. A skin assessment was not performed. LPN #5 also stated she was not directed to complete an incident report. Further interview revealed, she was aware of the abuse policy, however did not think anything had happened.</p>	N 105		
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N 105	Continued From page 17 In addition, review of the Emergency Department notes, dated 08/04/13 at 1:05 AM, revealed when Resident #1 presented to the emergency department for a possible sexual assault, the Emergency Department Physician documented the nursing facility staff had bathed Resident #1 and changed and washed Resident #1's clothing and linens prior to seeking emergency care. Interview with LPN #2, on 08/14/13 at 8:25 PM, revealed CNA #2 asked LPN #2 if she should bathe Resident #1. LPN #2 told CNA #2 to bathe Resident #1 although the facility's policy and procedures stated if sexual abuse was suspected, DO NOT bathe the resident or wash the resident's clothes or linen. Interview with the Director of Nursing, on 08/22/13 at 5:14 PM, revealed staff should have followed the facility's policy to not bathe or wash clothing or linens. Interview with the Corporate Executive Officer (CEO), on 08/14/13 at 8:55 PM, revealed she only obtained statements from the staff working on 08/03/13 after the State Police initiated their investigation. Per interview, she did not report the incident to the State Agencies, and did not complete a thorough investigation because she did not think anything had happened. Even though, the facility's policy and procedures revealed all suspected incidents of abuse were to be reported and upon receiving suspected reports of abuse, the Administrator or designee should report the incident to the appropriate State Agencies and investigations were to be conducted. Interview with the Administrator, on 08/21/13 at	N 105		

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N 105	Continued From page 18 2:42 PM, revealed an incident report and investigation should have been completed and the incident reported to the appropriate State Agencies per the facility's policy.	N 105		
N 108	902 KAR 20:300-5(3)(b) Section 5. Resident Behavior & Fac. Practice (3) Staff treatment of residents. (b) The facility shall have evidence that all alleged violations are thoroughly investigated, and shall prevent further potential abuse while the investigation is in progress. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure an alleged incident of sexual abuse was thoroughly investigated and reported immediately to the appropriate State Agencies for one (1) of nine (9) sampled residents (Resident #1). On 08/03/13 at 4:30 AM, Resident #2 was found in Resident #1's room with the door closed. Interview revealed Resident #1 was found in a fetal position on his/her side with the pajama pants and adult brief pulled down below the buttocks and the buttocks were exposed. A wet substance was found on Resident #1's buttocks, blanket, and on the outside of the adult brief. Interview revealed Resident #2 was sitting in his wheelchair with the zipper of his/her pants down. The facility was	N 108	SEE ATTACHED 9/16/13	

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N 108	<p>Continued From page 19</p> <p>unable to produce an incident report for the occurrence of the alleged sexual abuse; proof of an investigation; nor documented evidence the appropriate agencies were notified regarding the alleged sexual abuse.</p> <p>Based on the above findings, it was determined the facility's failure to investigate an alleged incident of sexual abuse and to immediately report the incident to the appropriate State Agencies, presents an imminent danger and creates substantial risk that death or serious mental or physical harm will occur. Imminent Danger was identified on 08/15/13 and was determined to exist on 08/03/13.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse Reporting" undated, revealed upon receiving suspected reports of abuse, misappropriation of property, or neglect, the Administrator or designee should report the incident to the appropriate authorities.</p> <p>Review of the facility's policy titled, "Accidents and Incidents" undated, revealed regardless of how minor an accident or incident may be, it should be reported to the department supervisor, and an Accident/Incident Report Form should be completed on the shift that the accident or incident occurred. Further review revealed the charge nurse and/or the department supervisor shall conduct an immediate investigation and submit it to the Director of Nursing Services.</p> <p>The State Survey Agency requested the incident report and investigation; however, the facility denied all requests.</p>	N 108		
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N 108	<p>Continued From page 20</p> <p>Review of Resident #1's Nursing Notes, dated 08/03/13 at 4:00 AM, revealed staff entered the closed door to Resident #1's room and found another resident in his/her room with the resident. Further record review revealed on 08/03/13 at 11:00 PM, an order was received from Resident #1's physician to transport Resident #1 to the emergency department for evaluation.</p> <p>Review of the Emergency Department notes, dated 08/04/13 at 1:05 AM, revealed Resident #1 presented to the emergency department for a possible sexual assault and a sexual assault evidence collection examination was completed.</p> <p>However, interview and record review revealed no documented evidence the facility completed an incident report; conducted a thorough investigation of the incident; or notified the appropriate State Agencies.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 08/15/13 at 7:06 PM, revealed LPN #5 was Resident #1's primary nurse and charge nurse. Further review revealed she found Resident #2 in Resident #1's room and notified her Manager on Duty who notified the Corporate Executive Officer (CEO).</p> <p>Interview with the Manager of Duty (MOD), on 08/16/13 at 3:34 PM, revealed she was notified by LPN #5 on 08/03/13 at approximately 4:30 AM of an incident involving Resident #2 being found in Resident #1's room with the door closed and that Resident #1's adult brief had been pulled down exposing his/her buttocks and the adult brief and linens had a wet sticky substance on them. The MOD stated she reported the information she received from LPN #5 to the CEO and also reported the staff were very upset. The</p>	N 108		
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N 108	<p>Continued From page 21</p> <p>MOD stated she was advised by the CEO that she (the CEO) would call LPN #5.</p> <p>Further interview with Licensed Practical Nurse (LPN) #5, on 08/15/13 at 7:06 PM, revealed the CEO called her for further information, but LPN #5 was not directed to complete an incident report. Further interview revealed, she was aware of the abuse policy, and did not follow the facility's policy to conduct an immediate investigation and document the incident because she did not think anything had happened. Further interview revealed she did not think anything had happened because Resident #2 could walk but he was in a wheel chair, Resident #1 had a fall mat beside his/her bed, Resident #2 could not remove his/her own pants, and was not in the room but maybe five (5) or ten (10) minutes and did not have enough time. Continued interview revealed Resident #2 could have gotten out of his/her wheel chair touched Resident #1 inappropriately and gotten back into his/her wheel chair.</p> <p>Interview with the CEO, on 08/14/13 at 8:55 PM, revealed she did not report the incident to the appropriate State Agencies because she was told by the reporting nurse (LPN #5), nothing happened. Continued interview revealed she was told Resident #2 was found in Resident #1's room with the door closed. Further interview revealed she was told Resident #1's pajama pants and adult briefs were pulled down and exposed his/her buttocks. She was also advised a wet substance was found on Resident #1's blanket. Further interview revealed when the State Police initiated their investigation, she requested witness statements from immediate care providers for the night of 08/03/13; however, a thorough investigation was not completed because she did</p>	N 108	

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N 108	<p>Continued From page 22</p> <p>not think anything had happened.</p> <p>Interview with CNA #1, on 08/14/13 at 7:54 PM, revealed the Corporate Executive Officer (CEO) requested witness statements from staff after the State Police initiated their investigations. However, interview revealed the CEO refused to take CNA #1's witness statement requesting CNA #1 re-write the statement including only facts of what she saw when she looked into the room. She stated the CEO wanted only what she saw, which was Resident #1 with his/her adult brief pulled down and blanket off. Further interview revealed CNA #1 was advised by the CEO, what Resident #2 had been doing before and after the incident was not relevant. CNA #1 stated she revised her statement; however, she gave her original statement to the State Police.</p> <p>Interview with Resident #1's legal guardian, on 08/21/13 at 1:58 PM, revealed she received a call on 08/04/13, with her phone's caller ID system identifying the caller to be from the facility, with a male voice stating he was a detective and the case [involving Resident #1] was closed. However, the Legal Representative confirmed with the police detective that he had not called her to advise the case was closed.</p> <p>Interview with the Assistant Administrator who was also Social Services Director, on 08/21/13 at 10:44 AM, revealed she was notified of the incident on 08/03/13 at approximately 9:30 AM. Further interview revealed she did not think anything had happened because Resident #2 was in a wheel chair and unable to walk and Resident #1 had a fall mat beside his/her bed. However, review of Resident #2's Nursing Notes dated 08/03/13 at 4:30 AM, revealed Resident #2 became agitated, got up out of his/her wheel</p>	N 108		

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N 108	<p>Continued From page 23</p> <p>chair, yelling foul curse words at staff, and was unable to be redirected.</p> <p>Interview with the Administrator, on 08/21/13 at 2:42 PM, revealed the Corporate Executive Officer (CEO) was on-call for 08/03/13. Further interview revealed the CEO notified her on 08/04/13 around 10:30 AM or 10:45 AM that Resident #2 was found in Resident #1's room with the door closed but had only been in the room less than five (5) minutes and staff removed Resident #2 immediately upon finding him/her. However, interview revealed she was not informed Resident #1's pajama pants and adult brief were pulled down and the blanket was wet with an unidentified substance. Continued interview revealed an incident report and investigation should have been completed. Further interview revealed the incident should have been reported per the facility's policy to the appropriate State Agencies.</p>	N 108		
N 130	<p>902 KAR 20:300-6(6)(a) Section 6. Quality Of Life</p> <p>(6) Social services. (a) The facility shall provide medically-related social services to attain or maintain the highest practicable physical, mental or psychosocial well-being of each resident. This requirement is not met as evidenced by: Based on interview, record review, review of Social Service Director Job Description, and the facility's policies, it was determined the facility failed to have an effective system to ensure residents in the facility received social services to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. On 08/03/13 at 4:00 AM, Resident #2 was found in Resident #1's room with the door</p>	N 130	SEE ATTACHED 9/16/13	

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N 130	<p>Continued From page 24</p> <p>closed. Interview revealed Resident #1 was found in a fetal position on his/her side with the pajama pants and adult brief pulled down below the buttocks and the buttocks were exposed. A wet substance was found on Resident #1's buttocks, blanket, and on the outside of the adult brief. Interview revealed Resident #2 was sitting in his wheelchair with the zipper of his/her pants down. Interview also revealed Resident #2 had a history of exhibiting inappropriate touching of Resident #1. Record review revealed Resident #2 would stare into other residents' rooms, cuss in the hallways, and make sexual comments; however, there was no documented evidence the facility had addressed Resident #2's behavior.</p> <p>In addition, record review revealed Resident #2 had a history of abusive behaviors towards other residents in the facility with no documented evidence Social Services addressed and implemented interventions related to these abusive behaviors.</p> <p>The facility's failure to ensure an effective system was in place to ensure social services were provided in order to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being of each resident presents an imminent danger to residents and creates a substantial risk that death or serious mental or physical harm will occur. The Imminent Danger was identified on 08/15/13, and determined to exist on 08/03/13. The facility was notified of the Imminent Danger on 08/15/13.</p> <p>The findings include:</p> <p>Review of the job description for Social Service Director (SSD) revealed Administrative Function of meeting with administration, medical and</p>	N 130		
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N 130	<p>Continued From page 25</p> <p>nursing staff, and other related departments in planning social services as needed. Further review revealed as a part of the Administrative Function, the Social Service Director was responsible for maintaining contact with the resident's family, involving them with non-medical progress reports and working with emotional problems including assisting resident/family with anxieties and stress caused by illness and admission to the facility, difficulties in coping with residual physical disabilities, fears related to helplessness and death, and the need for institutional and specialized care.</p> <p>Review of facility's policy "Behavior Policy", dated 06/07, revealed assessing/documenting new onset of behaviors or those behaviors that were not improving with treatment, monitoring for side effects and providing staff with information regarding behavior management via care plan, etc. Further review revealed nursing staff shall document in nurses notes of any concerns/changes (improvement/decline) with behaviors that require additional intervention or monitoring. Further review of the facility's policy revealed Social Services Designee (SSD) shall evaluate and document resident's mental health issues, past and present history of behavioral issues and shall incorporate with nursing information when documenting admission notes for use with Resident Assessment Instrument (RAI) to develop an appropriate plan of care. Further review revealed the SSD shall document at least quarterly thereafter and as needed regarding any noted changes in conditions, interventions implemented to assure an appropriate plan of care was instituted.</p> <p>1. Review of Resident #2's medical record revealed the facility admitted Resident #2 on</p>	N 130		

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N 130	<p>Continued From page 26</p> <p>02/12/13 with diagnoses which include Altered Mental Status, Seizure Disorder, Obstructive Hydrocephalus, Schizophrenia, Degenerative Joint Disease, and Mental Retardation. Review of Quarterly Minimum Data Set (MDS), dated 05/14/13, revealed a Brief Interview for Mental Status (BIMS) summary score of 11/15, indicating the resident was moderately impaired in cognition. Also noted was no evidence of acute changes in mental status. Review of the Nursing Notes, dated 08/03/13 at 4:00 AM, revealed staff entered the closed door to Resident #1's room and found Resident #2 in his/her room with the resident. Interview with staff revealed Resident #1 was found lying on his/her right side in a fetal position with his/her pajama pants and adult brief pulled down under the buttocks with his/her buttocks completely exposed. A wet substance was found on his/her hip, on the outer side of his/her adult brief, and on the resident's blanket.</p> <p>Interview with Resident #5, on 08/16/13 at 1:10 PM, revealed Resident #5 thought Resident #2 "was a problem from the start". Resident #5 could not recall specific dates and times but did reveal specific incidents when Resident #2 would reach towards Resident #1's breast and Resident #5 would intervene prior to any actual touching. Resident #5 stated the residents had to look out for Resident #1 and keep Resident #2 away from Resident #1.</p> <p>Review of Resident #5's medical record revealed the facility admitted Resident #5 on 07/19/12 with diagnoses which include Dementia, Depression, and Alzheimer's disease. Review of Annual MDS, dated 07/13/13, revealed BIMS summary score of 11/15, indicating the resident was interviewable. Also noted was no evidence of acute changes in mental status.</p>	N 130		

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N 130	Continued From page 27 Interview with Resident #4, on 08/16/13 at 12:59 PM, revealed Resident #4 had witnessed Resident #2 put his/her hand between Resident #1's legs. Continued interview revealed, Resident #4 advised staff to "keep an eye on" Resident #2 and keep him/her out of Resident #1's room. Further interview revealed Resident #4 did report his/her concerns to the Assistant Administrator/Social Services Director. Further interview with Resident #5, on 08/16/13 at 1:10 PM, revealed Unsampld Resident A had come into Resident #5's room and stated Resident #2 had come into his/her room and started talking about killing people. Unsampld Resident A told Resident #5 he/she was afraid of Resident #2. Resident #5 stated he/she encouraged Unsampld Resident A to report the incident to staff. Resident #5 stated she was present when Unsampld Resident A met with the Social Worker to inform of his/her fear of Resident #2. According to Resident #5, the Social Worker informed Unsampld Resident A not to worry about Resident #2 because he/she "wouldn't hurt anyone". Interview with Unsampld Resident A, on 08/20/13 at 4:55 PM, revealed Unsampld Resident A was upset by Resident #2 coming into his/her room. Unsampld Resident A stated he/she informed staff of the incident but couldn't remember to whom he/she reported it nor when it was reported. Review of Unsampld Resident A's medical record revealed the facility admitted Unsampld Resident A on 01/30/13 with diagnoses with include Osteoarthritis, Pain in Limb, Spinal Stenosis, Low Back Pain, Peripheral Vascular	N 130		

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N 130	Continued From page 28 Disease, Progressive Supranuclear Palsy, and Parkinsonism. Review of Quarterly MDS, dated 08/08/13, revealed BIMS summary score of 10/15, indicating the resident was interviewable. Interview with Social Services Director, on 08/21/13 at 10:45 AM, revealed she did not remember any resident discussing Resident #2 going into his/her room. The Social Worker further stated she didn't remember Resident #2 going into any other residents' room. The Social Worker stated if Resident #2 was in another resident's room, it was as a "wanted" visitor. The Social Worker stated she was not aware of Resident #2 making any sexual comments to staff or residents. 2. Review of Resident #2's medical record revealed documented evidence of Resident #2's behavior towards residents and staff. However, record review revealed no evidence these behaviors were addressed by Social Services. Review of the Nurse's Note, written on 02/28/13 at 9:10 AM, revealed Resident #2 was verbally abusive to residents and staff. Review of Resident #2's care plan revealed no documented evidence of revision or interventions put into place due to this behavior. Review of Nurse's Note, dated 04/10/13 at 9:00 PM, revealed Resident #2 was extremely upset, agitated and threatening to hurt his roommate. There was no documented evidence the Social Worker addressed Resident #2's behaviors. Review of Resident #2's care plan revealed no revision or interventions put into place due to this occurrence. Review of Nurse's Note, dated 04/27/13 at 12:15	N 130		

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N 130	<p>Continued From page 29</p> <p>PM, revealed Resident #2 was often found staring into other residents' rooms, cussing in the hallways, and making sexual comments. There was no documented evidence the Social Services Director addressed these behaviors. Review of Resident #2's care plan revealed no revision or interventions put into place due to this behavior.</p> <p>Interview with the Social Service Director, on 08/21/13 at 10:44 AM, revealed she was not aware of Resident #2's behaviors that were documented in the resident's medical record. Even though the facility's behavior policy stated the Social Services would evaluate and document resident's mental health issues, past and present history of behavioral issues, and incorporate nursing information to develop an appropriate plan of care.</p> <p>Further review of Nurse's Note, dated 05/20/13 at 6:30 PM, revealed Resident #2 was on the patio for smoke break and was yelling, cursing, and running into other residents with his/her wheel chair. There was no documented evidence the Social Services addressed this behavior and review of Resident #2's care plan revealed no revision or interventions put into place due to this behavior.</p> <p>Interview with the Social Service Director, on 08/21/13 at 10:45 AM, revealed she was unaware of the incident on 05/20/13 at 6:30 PM.</p> <p>However, interview with the DON, on 08/23/13 at 1:35 PM, revealed the 24 Hour Report/Change of Condition Reports, which were completed every day, were read during the morning meetings by supervisors and department heads.</p> <p>Review of facility's 24 Hour Report/Change of</p>	N 130		
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N 130	Continued From page 30 Condition Report, dated 05/20/13, revealed documentation of Resident #2 was yelling, cursing staff, running into residents, and staff was unable to redirect. However, Social Services failed to address this behavior and revise the resident's plan of care to prevent recurrence of this behavior and protect other residents. Interview with the Social Service Director, on 08/21/13 at 10:47 AM, revealed she was responsible for talking with residents and families regarding incidents in an investigation. Further interview revealed she was responsible for coordination of care within the facility to ensure residents received needed and required services. Further interview revealed she attended the morning meetings to discuss resident condition changes or pertinent information; however, she was unaware any residents were concerned with their safety, was unaware Resident #2 wandered into other resident rooms, was unaware Resident #2 had a history of staring into other resident rooms and was unaware Resident #2 had a history of making sexually inappropriate sexual comments.	N 130		
N 192	902 KAR 20:300-7(4)(b)3. Section 7. Resident Assessment (4) Comprehensive care plans. (b) A comprehensive care plan shall be: 3. Periodically reviewed and revised by a team of qualified persons after each assessment. This requirement is not met as evidenced by: Based on interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system to evaluate and	N 192	SEE ATTACHED 9/16/13	

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N 192	Continued From page 31 revise residents' care plans when a resident's status changed for one (1) of nine (9) sampled residents (Resident #2). Resident #2 had a documented history of verbal outburst, inappropriate touching, wandering in other residents' rooms, and running into other residents with his/her wheel chair. However, review of Resident #2's Care Plan revealed no documented evidence the facility revised the care plan to include interventions to address these behaviors. On 08/03/13 at 4:00 AM, Resident #2 was found in Resident #1's room with the door closed. Interview revealed Resident #1 was found in a fetal position on his/her side with the pajama pants and adult brief pulled down below the buttocks and the buttocks were exposed. A wet substance was found on Resident #1's buttocks, blanket, and on the outside of the adult brief. Interview revealed Resident #2 was sitting in his/her wheelchair with the zipper of his/her pants down. Based of the above findings, it was determined the facility's failure to to evaluate and revise residents' care plans when a change in status occurred presents an imminent danger to residents and creates substantial risk that death or serious mental or physical harm will occur. Imminent Danger was identified on 08/15/13 and was determined to exist on 08/03/13. The findings include: Review of facility's policy "Behavior Policy", dated 06/07, revealed assessing/documenting new onset of behaviors or those behaviors that were not improving with treatment, monitoring for side effects and providing staff with information regarding behavior management via care plan, etc. Further review revealed nursing staff shall	N 192		

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N 192	<p>Continued From page 32</p> <p>document in nurses notes of any concerns/changes (improvement/decline) with behaviors that require additional intervention or monitoring. Further review of the facility's policy revealed Social Services Director (SSD) shall evaluate and document resident's mental health issues, past and present history of behavioral issues and shall incorporate with nursing information when documenting admission notes for use with Resident Assessment Instrument (RAI) to develop an appropriate plan of care. Further review revealed the SSD shall document at least quarterly thereafter and as needed regarding any noted changes in conditions, interventions implemented to assure an appropriate plan of care was instituted.</p> <p>Review of facility's policy, "Care Plans - Comprehensive Policy", no date, revealed care plans should be revised as changes in the resident's condition dictated.</p> <p>Review of Resident #2's medical record revealed the facility admitted Resident #2 on 02/12/13 with diagnoses which include Altered Mental Status, Seizure Disorder, Obstructive Hydrocephalus, Schizophrenia, Degenerative Joint Disease, and Mental Retardation. Review of Quarterly Minimum Data Set (MDS), dated 05/14/13, revealed a Brief Interview for Mental Status (BIMS) summary score of 11/15 indicating the resident was moderately impaired in cognition. Also noted was no evidence of acute changes in mental status.</p> <p>Interview with Resident #5, on 08/16/13 at 1:10 PM, revealed specific incidents when Resident #2 would reach towards Resident #1's breast and Resident #5 would intervene prior to any actual touching. Resident #5 stated the residents had to</p>	N 192		
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N 192	<p>Continued From page 33</p> <p>look out for Resident #1 and keep Resident #2 away from Resident #1.</p> <p>Interview with Resident #4, on 08/16/13 at 12:59 PM, revealed Resident #4 had witnessed Resident #2 put his/her hand between Resident #1's legs. Resident #4 advised staff to "keep an eye on" Resident #2 and keep him/her out of Resident #1's room and Resident #4 reported his/her concerns to the Social Services Director.</p> <p>Review of Resident #2's Care Plan for Aggression, dated 02/12/13, revealed nursing staff to monitor moods and behaviors and document daily on the Mood and Behavior Tracker. The goal was for Resident #2 to have no moods/behaviors go undetected within the next assessment period. The interventions were implemented as needed to redirect, convey acceptance of resident during period of inappropriate behavior, always ask for help if resident becomes abusive/resistive, keep environment calm and relaxed, remove from public area when behavior is unacceptable, encourage diversional activities, change staff if resident will allow another staff to complete care, avoid over stimulation, assist to toilet or change brief as needed, position for comfort and assess for hunger or thirst. The only revisions to the care plan noted were for medication changes. Further review revealed a notation in the comment section of the comprehensive plan of care dated 05/2013 "Goals Met cont. POC". The resident's care plan did not address inappropriate touching of other residents.</p> <p>Review of the Nursing Notes, dated 08/03/13 at 4:00 AM, revealed staff entered the closed door to Resident #1's room and found Resident #2 in his/her room with the resident. Interview with</p>	N 192		
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N 192	<p>Continued From page 34</p> <p>staff revealed Resident #1 was found lying on his/her right side in a fetal position with his/her pajama pants and adult brief pulled down under the buttocks with his/her buttocks completely exposed. A wet substance was found on his/her hip, on the outer side of his/her adult brief, and on the resident's blanket.</p> <p>2. Review of Resident #2's medical record revealed Resident #2 exhibited behaviors towards residents and staff. However, review of the resident's plan of care revealed no changes in interventions to address these behaviors.</p> <p>Review of Resident #2's Mood and Behaviors Monthly Assessment, 02/2013, revealed verbal and physical abuse documented on 02/28/13. Other behaviors were also documented to include other behavioral symptoms not directed toward others, rejection of care, inattention and disorganized thinking. No documentation indicating intervention of medication was used. Outcomes were recorded as unchanged and the resident's care plan was not revised. Review of the Nurse's Note, dated 02/28/13 at 9:10 AM, revealed Resident #2 to be verbally abusive to other residents and staff and extremely upset and unable to be redirected. Further review of the medical record revealed Resident #2 received PRN dose of Ativan for agitation/anxiety. However, review of the Care Plan revealed no documented evidence the facility revised the care plan to included updated interventions to address the behaviors.</p> <p>Review of Resident #2's Mood and Behaviors Monthly Assessment, 04/2013, revealed no abusive behaviors documented although other behaviors such as inattention and disorganized thinking were documented. No documentation</p>	N 192		
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N 192	<p>Continued From page 35</p> <p>indicating intervention of medication was used. Outcomes were recorded as unchanged. However, review of Resident #2's Nurse's Notes, dated 04/09/13 at 7:00 AM, revealed Resident #2 was up in his/her wheel chair roaming the facility making sexual remarks to staff. Resident #2 was redirected with positive results. Review of Resident #2's Nurse's Note, dated 04/10/13 at 9:00 PM, revealed Resident #2 was extremely upset and agitated. Review revealed Resident #2 threatened to hurt his/her room mate. At this time Resident #2 received PRN dose of Ativan for agitation/anxiety. Review of Resident #2's Nurse's Notes, dated 04/27/13 at 12:15 PM, revealed Resident #2 was often found strolling in other resident rooms, cussing in hallways and making sexual comments. Review of Resident #2's Nurse's Note, dated 04/28/13 at 5:30 PM, revealed Resident #2 was yelling and cussing in the hall, threatening to fight other residents and staff, packing his/her personal belongings. Further review revealed Resident #2 received PRN dose of Ativan for agitation/anxiety. However, review of the care plan revealed no documented evidence the care plan was revised to include any additional interventions to address Resident #2's behaviors.</p> <p>Review of Resident #2's Mood and Behaviors Monthly Assessment, 05/2013, revealed no abusive behaviors documented although other behaviors were documented to include inattention and disorganized thinking. No documentation indicating intervention of medication was used. Outcomes were record as unchanged. However, review of Resident #2's Nurse's Note, dated 05/13/13 at 11:00 PM, revealed Resident #2 required frequent redirection from conversation with staff regarding sexual overtones. Review of Resident #2's Nurse's Note, dated 05/20/13 at</p>	N 192		
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N 192	Continued From page 36 6:30 PM, revealed Resident #2 was on the patio outside, very agitated, going through the trash can, yelling, cursing and running into other residents and unable to be redirected. Further review revealed Resident #2 received PRN dose of Ativan for agitation/anxiety at 7:00 PM. Review of Resident #2's Nurse's Note, dated 05/31/13 at 2:45 PM, revealed Resident #2 was cussing and threatening staff and other residents. Resident #2 received PRN dose of Ativan for agitation/anxiety. However, review of the care plan revealed no documented evidence the care plan was revised with interventions to address the behaviors. Review of Resident #2's Mood and Behaviors Monthly Assessment, 07/2013, revealed physically abusive behaviors documented on 07/01/13. Other behaviors were noted on 07/01/13, 07/02/13, 07/20/13, 07/22/13, 07/23/13 and 07/24/13 to include other behavioral symptoms not directed toward staff, rejection of care, inattention, disorganized thinking and delusions. No documentation indicating intervention of medication was used. Outcomes were record as unchanged. However, review of Resident #2's Nurse's Note, dated 07/26/13 at 10:30 AM, revealed the Inter-Disciplinary Team (IDT) reviewed the resident's behaviors from evening shift. Further review stated Resident #2 became very angry and irate, cussing at other staff, throwing things. Resident #2 received PRN dose of Ativan for agitation/anxiety. Review of Resident #2's Nurse's Note, dated 07/26/13 at 8:15 PM, revealed Resident #2 was yelling and stating to staff to get away or he/she would hurt staff. Resident #2 was cursing other residents when they told him to shut up. Resident #2 was unable to be re-directed. Resident #2 received PRN dose of Ativan for agitation/anxiety.	N 192		

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N 192	<p>Continued From page 37</p> <p>However, review of the care plan revealed no documented evidence the care plan was revised to include addition interventions to address the behaviors.</p> <p>Review of Resident #2's Mood and Behaviors Monthly Assessment, from 08/01/13 to 08/03/13, revealed no abusive behaviors documented although other behaviors were documented to include inattention and disorganized thinking. No documentation indicating intervention of medication was used. Outcomes were record as unchanged. However, review of Resident #2's Nurse's Note, dated 08/03/13 at 4:30 AM, revealed Resident #2 was roaming in the hall and became agitated and unable to redirect. Further review revealed Resident #2 got up out of his/her wheel chair saying he/she was leaving, resident yelling and cursing staff unable to redirect. Resident #2 received PRN dose of Ativan for agitation/anxiety at 4:50 AM.</p> <p>Interview with the Director of Nursing (DON), on 08/21/13 at 11:30 AM, revealed the Mood and Behavior Tracking sheets were probably not accurate due to not recording interventions of medications given and the effectiveness of the interventions.</p> <p>Interview with the Social Service Director, on 08/21/13 at 10:59 AM, revealed it was her responsibility to coordinate services in the facility to ensure residents received the care and services that they needed. She stated she did, at times revise care plans.</p> <p>Interview with the Chief Executive Officer (CEO), on 08/21/13 at 1230 PM, revealed she was not able to determine if the Mood and Behavior Tracking sheets were an accurate assessment of</p>	N 192		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/23/2013
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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N 192	<p>Continued From page 38</p> <p>the resident's behavior if the sheets were missing important details, due to not having a medical background.</p> <p>Interview with the Administrator, on 08/21/13 at 2:40 PM, revealed she does not review the Mood and Behavior tracking sheets to assess residents. The Administrator stated she looked at the nurse's notes, medications, and Physician's orders to assess behaviors. She further stated the Social Service Director was responsible for review the Mood and Behavior tracking sheet and revising the care plan accordingly.</p>	N 192		
N 316	<p>902 KAR 20:300-15 Section 15. Administration</p> <p>A facility shall 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.</p> <p>This requirement is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to be administered in a manner which enables it to attain or maintain the highest practicable physical well-being of each resident related to provision of care. The facility failed to ensure abuse and care plan policies and procedures were implemented by staff. The facility failed to develop and implement a behavior management program to ensure residents' behaviors that could lead to conflict were assessed, care planned, and monitored. The facility's administration failed to ensure Social Services related to residents'</p>	N 316	SEE ATTACHED 9/16/13	

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N 316	<p>Continued From page 39</p> <p>behaviors was involved in assessing and implementing interventions to ensure care plan revision to ensure resident behaviors were addressed to ensure resident safety.</p> <p>On 08/03/13 at 4:30 AM, Resident #2 was found in Resident #1's room with the door closed. Interview revealed Resident #1 was found in a fetal position on his/her side with the pajama pants and adult brief pulled down below the buttocks and the buttocks were exposed. A wet substance was found on Resident #1's buttocks, blanket, and on the outside of the adult brief. Interview revealed Resident #2 was sitting in his wheelchair with the zipper of his/her pants down. Interview and record review revealed Resident #1 was not assessed for injury, nor was the resident's Physician or Responsible Party immediately notified of the incident. Interview and record review revealed the facility failed to investigate the incident and report the incident to the appropriate State Agencies. Interview also revealed Resident #2 had a history of exhibiting inappropriate touching of Resident #1. Record review revealed Resident #2 would stare into other residents' rooms, cuss in the hallways, and make sexual comments; however, there was no documented evidence the facility had addressed Resident #2's behavior.</p> <p>Based on the above findings it was determined the facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently presents an imminent danger and creates a substantial risk that death or serious mental or physical harm will occur. Imminent Danger was identified on 08/15/13, and was determined to exist on 08/03/13.</p>	N 316		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X7) DATE SURVEY COMPLETED C 08/23/2013	
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
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N 316	<p>Continued From page 40</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Rights" undated, revealed the residents had the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion. Continued review revealed the facility must implement procedures that protect the resident from abuse, neglect or mistreatment, or misappropriation of property. Further review revealed in the event of an alleged violations involving resident treatment, the facility was required to report it to the appropriate officials and all alleged violations must be thoroughly investigated and the results reported. Further review revealed the facility must provide a safe environment.</p> <p>Review of the facility's policy titled, "Abuse Reporting" undated, revealed the definitions of Abuse, Verbal abuse, Sexual abuse, Physical abuse, Involuntary seclusion, Mental abuse, Neglect and Misappropriation of resident property were each defined in the policy. Further review revealed each person observing an incident of resident abuse or suspected resident abuse should be immediately reported to the charge nurse. Review further revealed the charge nurse should complete an Incident Report Form and should examine and interview the resident and report all findings to the Administrator or designee. Additionally, review of the facility's policy stated if sexual abuse was suspected, DO NOT bathe the resident or wash the resident's clothes or linen.</p> <p>Review of the facility's policy titled, "Care Plans - Comprehensive" undated, revealed the Comprehensive Care Plan was designed to incorporate identified problem areas and</p>	N 316		

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N 316	<p>Continued From page 41</p> <p>incorporate risk factors associated with the identified problem areas. Further review revealed the Care Plans were revised as changes in the resident's condition dictates.</p> <p>Review of the facility's policy titled, "Behavior Policy" dated 06/07, revealed Social Services (SS) should evaluate and document resident's mental health issues, past and present history of behavioral issues and shall incorporate said information with nursing information when documenting to develop an appropriate plan of care. Further review revealed SS should document at least quarterly thereafter and as needed regarding any noted changes in conditions, interventions implemented to assure appropriate plan of care is instituted. Further review revealed residents exhibiting behaviors that posed an immediate threat/harm to themselves or others will have physician/responsible party notified for request to discharge to hospital for assuring safety. Further review revealed the residents would receive individualized interventions based on behaviors until transportation could be arranged.</p> <p>Interview and record review revealed the facility had been knowledgeable of Resident #2's history of abusive/inappropriate behaviors since 02/28/13; however, failed to assess, care plan, and monitor Resident #2 related to these abusive behaviors. Record review revealed Resident #2 had made sexual comments to staff, and resident interviews revealed residents had witnessed Resident #2 inappropriately touch Resident #1. Residents reported they had told facility staff and stated they were concerned for Resident #1. However, interviews with staff revealed they denied being informed of this behavior.</p>	N 316		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/23/2013
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N 316	Continued From page 42 Review of the Nursing Notes, dated 08/03/13 at 4:00 AM, revealed staff entered the closed door to Resident #1's room and found Resident #2 in his/her room with the resident. Staff interviews revealed Resident #1's left hip and buttocks were exposed and Resident #1 was found to have a wet substance on his/her hip, on the outer side of his/her adult brief, and on the resident's blanket. However, this incident was not immediately reported to Resident #1's physician or legal representative and the resident was not assessed by the facility for injury. In addition, the facility failed to conduct a thorough investigation, and failed to notify the appropriate State Agencies. Interview with the Corporate Executive Officer (CEO), on 08/14/13 at 8:55 PM, revealed she did not report the incident to the appropriate State Agencies because she was told by the reporting nurse (LPN #5), nothing happened. Further interview revealed when the State Police initiated their investigation, she requested witness statements from immediate care providers for the night of 08/03/13; however, a thorough investigation was not completed because she did not think anything had happened. Interview with the Director of Nursing, on 08/21/13 at 11:29 AM, revealed her expectations would be to follow the facility's policies. Further interview revealed Resident #2 should have been care planned for behaviors with interventions in place to monitor Resident #2 and protect the other residents. Further interview revealed all incidents should be documented, investigated and reported to the appropriate State Agencies. Interview with the Administrator, on 08/21/13 at 2:42 PM, revealed facility policy and procedures should be followed; an incident report and	N 316			

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N 316	Continued From page 43 investigation should be completed for all allegations of abuse; and, the allegation should be reported to the appropriate State Agencies.	N 316	

Please note: following terminology for entire POC when abbreviated, etc.

- **QI= Quality Improvement team** (members are all Dept. Heads assigned to know respective residents, inspect common areas which end up inspecting all residents/areas in facility)
- **QA= Quality Assurance** (checks to assure that QI/compliance and systems are effective) Team includes Medical Director, Administrator/designee, Nursing Management, SS Director, Human Resources/designee, Housekeeping/Maint. Supervisor, and other Dept. Heads in general). Includes QI/clinical care quality indicators, survey results, policy changes, etc.
- **Weekly Clinical Meetings** (Usually held middle of week, Wed. or Thurs.) and includes Nurse manager, Admin/designee, Social Services/designee, therapy, and other QI members as needed.
- **IDT (interdisciplinary team)** other wise known as **CP** (care plan team- same as clinical team)
- **MOD= Manager on Duty** assigned on weekends (consists of QI dept. heads)
- Please refer to **F490** to reveal audit forms, inservices, dates, detailed information if lacking elsewhere for reference.
- ❖ **If no date given/or states as of compliance date: then be assured all performed prior to 9/16/13**

**Plan of Correction/Allegation of Compliance for N018 Notify of Changes
Sampled Residents; R1 and R2**

Interventions responses to answers for POC questions:

#1) Sampled R2 no longer resides in facility as of 8/3/13. POA/MD notified with condition 8/3/2013 prior to DC and no further changes in care plan or notifications required after discharge. Sampled R1 remains in facility as of this date. R1's MD and POA notified as needed as of compliance date for changes in unexpected changes in condition/per policy, etc. OIG notified on 9/8/13 as well regarding incident along with MD/POA. No additional treatment/orders needed for said occurrence. Skin assessment audited after licensed nurse performed to assure accuracy and signed off on form for R1 on 9/8/13 and repeated as of compliance date. (this is in addition to survey team performing skin assessments prior to exit). No further repeat/similar incidents as noted for 8/3/13 date. R1 had no adverse outcomes per hospital and agency reports for 8/3/13 incident and also after 9/8/13 reporting (same resident both isolated deficiencies).

#2) All residents have potential to be affected by said practice. No other residents identified/had any adverse effects based on alleged deficient practice as of compliance date (9/16/13). DON, CPC, Admin/designee assured Compliance by checking/comparing nurses' 24 hr reports, incidents, careplans and skin assessments for residents as of compliance date to assure Policy for notifying MD/POA/other agencies as needed ongoing when listed on 24 hour report, having new MD order for change in condition/notification of incident report completed, and with performing additional assessments when MDS due which includes checking treatment record which included all residents when reviewing as of compliance date. Information included with weekly Quality Improvement (QI) clinical dept. heads to be transcribed onto an audit form as completed after reviewing internal/confidential quality assurance information. This was assured by DON/designee as of compliance date. Shall repeat QA audit form for proof of performing x 30 days. (see below for detailed inservicecs/audits/monitoring with dates performed in addition on how assured no other residents (other than R1) were affected by said practice). Was also assured during QA meetings with review of audits for skin assessments, incidents/accidents, etc. as noted below as of 9/15/13.

#3/4 Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty, (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding notification of changes/policy including requirements for notification when there is an accident/incident per policy on: 8/23/13, 8/26/13, 9/13/13 at minimum to perform rounds and check, in addition to nursing staff, if any

incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy. QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least 3 times weekly in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members.

Administrator/Executive Director/DON gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/9/13 and 9/13/13 (along with individual ones to new staff/others as needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Notification requirements, and covered all issues regarding regulatory/policy requirements for duties, policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.)

Ombudsmen/SS Director/designee gave inservices to residents/staff and/or interviewed/talked to residents/responsible party on at least following dates: both prior to and as of 8/23/13, 9/4/13, and repeated ongoing as noted in remainder of this paragraph as of 9/15/13. These are in addition to discussing at Care Plan meetings held both prior and as of date of compliance (9/16/13) regarding resident rights, assess concerns, etc. Information of resident rights also given upon admission and at least annually thereafter as well which addresses all resident rights/abuse/reporting grievances/notifications with care/etc. EYI: Ombudsmen and SS Director/designee have assured that all residents/families understand resident rights/abuse/reporting protocol/grievances as of compliance date (9/16/13). No similar grievances voiced with Ombudsman, who is in on bi-monthly basis at minimum, in addition to monthly Resident Council meetings held and assured compliance as of 9/15/16 with amount of interaction from QI team doing rounds/Ombudsmen's interviews/review of SS grievance reports/in addition to what Nursing Management performing as noted above to assure notifications/reporting has occurred as of 9/15/13. This information transcribed onto audit form that information was included with the weekly clinical meetings and QA meetings held, and initialed off as completed on form. Done weekly after survey exit and shall continue times minimum of 4 weeks on audit form for POC.

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit. (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days)

Date of Compliance: 9/16/2013.

Responsible: Administrator/Director of Nursing.

Plan of Correction/Allegation of Compliance for N039 Personal Privacy/Confidentiality of Records

#1) The 300 hall (East Hall) bathroom had a privacy curtain placed in the room around resident bathing area to maintain privacy to the residents as of 8/23/13. Facility corrected prior to survey exit, no further issues noted with curtain being down or not closed to assure privacy to nursing personnel only as of compliance date.

#2) All residents have potential to be affected by said practice. Facility has 3 general common shower rooms-as well privacy curtains in rooms. No other rooms have been identified as being non-compliant and privacy assured by designated quality improvement dept heads (QI members) performing daily rounds during normal work days and Manager on Duty (MOD) performing rounds and document on rounds tool of assuring staff assuring privacy during rounds in addition to Licensed Charge Nurses making rounds. These rounds turned into Administrator/designee for review. Admin/designee shall document on audit form on weekly basis times 30 days as being completed to give for revisit. QI rounds check list include that common areas as well as resident rooms were inspected for privacy curtains up/utlized, dignity/privacy assured, along with many other items for their designated areas. (which all combined monitor every resident/area in facility). (see below for inservices) Dates audited in addition by DON in addition to QI rounds tools given to Admin/designee: 8/23/13, 8/26/13, 8/29/13, 9/3/13

#3/4) QI members checking to assure while performing rounds on a daily basis/ MOD on weekends, and then given to Admin/designee to check compliance and transfer onto an audit form at least weekly at minimum with weekly QI/clinical meetings that staff honoring resident right to privacy/dignity including privacy while bathing in rooms as well. All residents have potential to have privacy/respect issues affected by said practice, and no further complaints reported or other residents affected regarding said practice after interviews conducted by Ombudsman and or SS Director/designee both prior to 8/23/13 and again on 9/4/13. Assured by QI team and QA members as of 9/15/13. Audit forms shall continue by respective QI team times 30 days to be turned in for QA assurance.

Administrator/designee in-serviced Department Managers/QI Members/Managers on Duty both prior to survey exit and on 8/23/13, 8/26/13, 9/13/13 at minimum. regarding policy/privacy/dignity, including resident right to privacy while bathing. This included their responsibilities for completing QI rounds tool and reporting if note any concerns.

DON/designee in-serviced/re-in-serviced nursing staff (nurses, CNA's, KMA's as well as general all staff) regarding dignity/privacy/resident bathing after survey exit on: 8/23/13, 8/29/13, /9/13/13. This is in addition to new staff, and individual inservices given pm from 8/23/13-9/15/13 and shall be available for review.

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit. (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than

pleased with QA discussions/monitoring/audits.(These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days

Date of Compliance: 9/16/13

Responsible: Administrator

**Plan of Correction/Allegation of Compliance for N104 Freedom from Abuse/Involuntary Seclusion
Sampled Residents: R1 and R2**

Interventions responses to answer for POC questions:

#1) Sampled R2 no longer resides in facility as of 8/3/13. POA/MD notified with condition 8/3/2013 prior to DC and no further changes in care plan or notifications required after discharge. Sampled R1 remains in facility as of this date. R1's MD and POA notified as needed as of compliance date for changes in unexpected changes in condition/per policy, etc. OIG notified on 9/8/13 as well regarding incident along with MD/POA. No additional treatment/orders needed for said occurrence. Skin assessment audited after licensed nurse performed to assure accuracy and signed off on form for R1 on 9/8/13 and repeated as of compliance date (this is in addition to survey team performing skin assessments prior to exit). No further repeat/similar incidents as noted for 8/3/13 date. R1 had no adverse outcomes per hospital and agency reports for 8/3/13 incident and also after 9/8/13 reporting (same resident both isolated deficiencies).

#2) All residents have potential to be affected by said practice. No other residents identified/had any adverse effects based on alleged deficient practice as of compliance date (9/16/13). DON, CPC, Admin/designee assured Compliance by checking/comparing nurses' 24 hr reports, incidents, careplans and skin assessments for residents as of compliance date to assure Policy for assuring no allegations of suspected abuse/documentation/investigations, etc not adhered to policy/regulations as needed ongoing DON/designee reviews residents as listed on 24 hour report, having new MD order for change in condition/notification of incident report completed, and with performing additional assessments when MDS due which includes checking treatment record which included all residents when reviewing as of compliance date. Information included with weekly Quality Improvement (QI) clinical dept. heads to be transcribed onto an audit form as completed after reviewing internal/confidential quality assurance information. This was assured by DON/designee as of compliance date. Shall repeat QA audit form for proof of performing x 30 days. DON and Nurse Managers audited residents who were at risk (14 residents) for behaviors, safety, abuse and wandering first as of survey exit 8/23/13 then all residents assured no additional allegations/similar incident examples based on above audits along with plan of care again as of 9/13/13.

(see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no other residents (other than R1 alleged by said practice). Also assured during QA meetings with review of audits for skin assessments, incidents/accidents, etc. as noted below as of 9/15/13.

#3/4 Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty, (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding behaviors/incidents that require investigation of alleged possible harm, notification of changes/policy including types of abuse/reporting/responsibilities on: 8/23/13,8/29/13,9/13/13 at minimum to perform rounds and check, in addition to nursing staff, if any incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy.

Administrator/Executive Director/DON gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/13/13. (along with individual ones to new staff/others as needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Notification requirements, and covered all issues regarding regulatory/policy requirements for duties,

policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.)
(In addition: facility scheduled for outside RSS consultant company to give in-service to general all staff regarding abuse/reporting/resident rights on 8/29/13.

Ombudsmen/SS Director/designee gave inservices to residents/staff and/or interviewed/talked to residents/responsible party on at least following dates: both prior to and as of 8/23/13, 9/4/13, and repeated ongoing as noted in remainder of this paragraph as of 9/15/13. These are in addition to discussing at Care Plan meetings held both prior and as of date of compliance (9/16/13) regarding resident rights, assess concerns, etc. Information of resident rights also given upon admission and at least annually thereafter as well which addresses all resident rights/abuse/reporting grievances/notifications with care/etc. FYI: Ombudsmen and SS Director/designee have assured that all residents/families understand resident rights/abuse/reporting protocol/grievances as of compliance date (9/16/13). No similar grievances voiced with Ombudsman, who is in on bi-monthly basis at minimum, in addition to monthly Resident Council meetings held and assured compliance as of 9/15/13 with amount of interaction from QI team doing rounds/Ombudsmen's interviews/review of SS grievance reports/in addition to what Nursing Management performing as noted above to assure notifications/reporting has occurred as of 9/15/13. This information transcribed onto audit form that information was included with the weekly clinical meetings and QA meetings held, and initialed off as completed on form. Done weekly after survey exit and shall continue times minimum of 4 weeks on audit form for POC.

Audits included: DON/designee comparing incident/accident reports, 24 hr nurses' report sheet, Nurses Notes, Care Plans for all and especially if have aggressive behaviors/wandering/other high risk factors along with Care plans. Residents listed on 24 hr reports, had incident that results in investigation/interventions continue to be audited/assessed for compliance on work days as well as the MOD duty/Nurse Manager on call weekend reports as of compliance date and shall continue ongoing. Internal QI/incident report/other QI audits shall be transcribed onto an audit form that Admin/designee shall sign during weekly QI/weekly clinical meetings at a minimum to show compliance times 30 days as well as including detailed information with QA meetings for any noted concerns/need for additional changes.

QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department lead staff members

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit. (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days

Date of Compliance: 9/16/2013.

Responsible: Administrator/Director of Nursing.

Plan of Correction/Allegation of Compliance for N105 Investigate/Report/Allegations/Individuals Sampled R1

Interventions responses to answers for POC questions: Not able to do/email on 2567 itself

#1) Sampled R2 no longer resides in facility as of 8/3/13. POA/MD notified with condition 8/3/2013 prior to DC and no further changes in care plan or notifications required after discharge. Sampled R1 remains in facility as of this date. R1's MD and POA notified as needed as of compliance date for changes in unexpected changes in condition/per policy, etc. OIG notified on 9/8/13 as well regarding incident along with MD/POA. No additional treatment/orders needed for said occurrence. Skin assessment audited after licensed nurse performed to assure accuracy and signed off on form for R1 on 9/8/13 and repeated as of compliance date. (this is in addition to survey team performing skin assessments prior to exit). No further repeat/similar incidents as noted for 8/3/13 date. R1 had no adverse outcomes per hospital and agency reports for 8/3/13 incident and also after 9/8/13 reporting (same resident both isolated deficiencies).

#2) All residents have potential to be affected by said practice. No other residents identified/had any adverse effects based on alleged deficient practice as of compliance date (9/16/13). DON, CPC, Admin/designee assured Compliance by checking/comparing nurses' 24 hr reports, incidents, careplans and skin assessments for residents as of compliance date to assure Policy for notifying MD/POA/other agencies as needed ongoing when listed on 24 hour report, having new MD order for change in condition/notification of incident report completed, and with performing additional assessments when MDS due which includes checking treatment record which included all residents when reviewing as of compliance date. Information included with weekly Quality Improvement (QI) clinical dept. heads to be transcribed onto an audit form as completed after reviewing internal/confidential quality assurance information. This was assured by DON/designee as of compliance date. Shall repeat QA audit form for proof of performing x 30 days. (see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no other residents (other than R1 were affected by said practice). Was also assured during QA meetings with review of audits for skin assessments, incidents/accidents, etc. as noted below as of 9/15/13.

#3/4 Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty, (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding notification of changes/policy including requirements for notification when there is an accident/incident per policy on: 8/23/13, 8/26/13, 9/13/13 at minimum to perform rounds and check, in addition to nursing staff, if any incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy. QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least 3 times weekly in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members.

Administrator/Executive Director/DON gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/9/13 and 9/13/13 (along with individual ones to new staff/others as needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Notification requirements, and covered all issues regarding regulatory/policy requirements for duties, policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.)

Ombudsmen/SS Director/designee gave inservices to residents/staff and/or interviewed/talked to residents/responsible party on at least following dates: both prior to and as of 8/23/13, 9/4/13, and repeated ongoing as noted in remainder of this paragraph as of 9/15/13. These are in addition to discussing at Care Plan meetings held both prior and as of date of compliance (9/16/13) regarding resident rights, assess concerns, etc. Information of resident rights also given upon admission and at least annually thereafter as well which addresses all resident rights/abuse/reporting grievances/notifications with care/etc. FYI: Ombudsmen and SS Director/designee have assured that all residents/families understand resident rights/abuse/reporting protocol/grievances as of compliance date (9/16/13). No similar grievances voiced with Ombudsman, who is in on bi-monthly basis at minimum. in addition to monthly Resident Council meetings held and assured compliance as of 9/15/16 with amount of interaction from QI team doing rounds/Ombudsmen's interviews/review of SS grievance reports/in addition to what Nursing Management performing as noted above to assure notifications/reporting has occurred as of 9/15/13. This information transcribed onto audit form that information was included with the weekly clinical meetings and QA meetings held, and initialed off as completed on form. Done weekly after survey exit and shall continue times minimum of 4 weeks on audit form for POC.

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit. (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days)

Date of Compliance: 9/16/2013.

Responsible: Administrator/Director of Nursing.

Plan of Correction/Allegation of Compliance for N108 Develop/Implement Abuse/Neglect etc. Policies

#1-Administrator reviewed/re-reviewed abuse policy with QA team again on 8/23/13, 9/4/13 and assured compliance as of 9/16/13 again based on outcome of audits/no compliance issues as listed below. Inservices regarding abuse, policy, reporting given as listed below.) Sampled R2 no longer resides in facility as of 8/3/13. Sampled R1 remains in facility as of this date. R1's MD and POA notified as needed as of compliance date for changes in unexpected changes in condition/per policy, etc. OIG notified on 9/8/13 as well regarding incident along with MD/POA. No additional treatment/orders needed for said occurrence. Skin assessment audited after licensed nurse performed to assure accuracy and signed off on form for R1 on 9/8/13 and repeated as of compliance date. (this is in addition to survey team performing skin assessments prior to exit). No further repeat/similar incidents as noted for 8/3/13 date.

#2) All residents have potential to be affected by said practice. No other residents had any adverse effects based on alleged deficient practice as of compliance date (9/16/13). DON, CPC, Admin/designee assured Compliance by checking/comparing nurses' 24 hr reports, incidents, careplans and skin assessments for residents as of compliance date to assure Policy for notifying MD/POA/other agencies as needed ongoing when listed on 24 hour report, having new MD order for change in condition/notification of incident report completed, and with performing additional assessments when MDS due which includes checking treatment record which included all residents when reviewing as of compliance date. Information included with weekly Quality Improvement (QI) clinical dept. heads to be transcribed onto an audit form as completed

after reviewing internal/confidential quality assurance information. This was assured by DON/designee as of compliance date. Shall repeat QA audit form for proof of performing x 30 days. (see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no residents affected by said practice/policy. Was also assured during QA meetings with review of audits as of 9/15/13.

#3/4 Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty, (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding notification of changes/policy including requirements for notification when there is an accident/incident per policy on: 8/23/13, 8/26/13, 9/13/13 at minimum to perform rounds and check, in addition to nursing staff, if any incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy. QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least 3 times weekly in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members.

Administrator/Executive Director/DON gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/9/13 and 9/13/13 (along with individual ones to new staff/others as needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Notification requirements, and covered all issues regarding regulatory/policy requirements for duties, policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.)

Ombudsmen/SS Director/designee gave inservices to residents/staff and/or interviewed/talked to residents/responsible party on at least following dates: both prior to and as of 8/23/13, 9/4/13, and repeated ongoing as noted in remainder of this paragraph as of 9/15/13. These are in addition to discussing at Care Plan meetings held both prior and as of date of compliance (9/16/13) regarding resident rights, assess concerns, etc. Information of resident rights also given upon admission and at least annually thereafter as well which addresses all resident rights/abuse/reporting grievances/notifications with care/etc. EYI: Ombudsmen and SS Director/designee have assured that all residents/families understand resident rights/abuse/reporting protocol/grievances as of compliance date (9/16/13). No similar grievances voiced with Ombudsman, who is in on bi-monthly basis at minimum, in addition to monthly Resident Council meetings held and assured compliance as of 9/15/16 with amount of interaction from QI team doing rounds/Ombudsmen's interviews/review of SS grievance reports/in addition to what Nursing Management performing as noted above to assure notifications/reporting has occurred as of 9/15/13. This information transcribed onto audit form that information was included with the weekly clinical meetings and QA meetings held, and initialed off as completed on form. Done weekly after survey exit and shall continue times minimum of 4 weeks on audit form for POC.

Audits included: DON/designee comparing incident/accident reports, 24 hr nurses' report sheet, Nurses Notes, Care Plans for all and especially if have aggressive behaviors/wandering/other high risk factors along with Care plans. Residents listed on 24 hr reports, had incident that results in investigation/interventions continue to be audited/assessed for compliance on work days as well as the MOD duty/Nurse Manager on call weekend reports as of compliance date and shall continue ongoing. Internal QI/incident report/other QI audits shall be transcribed onto an audit form that Admin/designee shall sign during weekly QI/weekly clinical meetings at a minimum to show compliance times 30 days as well as including detailed information with QA meetings for any noted concerns/need for additional changes.

QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit. (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days)

Date of Compliance 9/16/2013.

Responsible: Administrator/Director of Nursing.

Plan of Correction/Allegation of Compliance for N130 Provision of Medically Related Social Services

- #1- To ensure compliance with F250 Administrator/designee reviewed/repeated duties, interventions to report grievance issues not resolved timely regardless of whether or not reportable, and reviewed the role/responsibility of social services as of 8/23/13, 8/27/13, 9/4/13. This includes to notify Administrator if seeing non-compliance with grievance reports from other dept. manager, providing information along with Ombudsman, audits, documentation. Social Services Director voiced understanding of regulation and ensured that she was competent on policy/procedures. SS Director also attended inservice given by Risk Management Consultant regarding abuse, etc. as given with nursing staff on 8/29/13. Sampled R2 no longer resides in facility as of 8/3/13. Sampled R1 remains in facility as of this date. R1, In addition to SS Director/QI team, has PASSR Social Services assist with Social Services with monthly visits (varies based on outside SS specialist schedule and R1's willingness to participate to assist with plan of care. Communication continues ongoing as needed per policy to POA/MD to keep involved via phone regarding overall plan of care issues/interventions/issues with disease expectations and unexpected changes in condition as of compliance date.
- #2 All residents have potential to be affected by said practice per policy. No other residents identified/had any adverse effects based on alleged deficient practice. Social Service Director shall give to Administrator/designee grievance reports on at least weekly basis for review/auditing compliance of assuring appropriate actions/forms/documentation and follow up done per designated department head as of compliance date then times additional 30 days. Shall be initialed off as completed on monitoring form by administrator to show internal QA information was reviewed/compliance achieved. (No residents have been affected as audits completed were documented and assured follow up as of 9/14/13 when reviewed along with QA meeting held on 9/4/13 showing inservices/documentation/care plan updates appropriate as listed below along with Ombudsman interviewing residents and/or responsible parties prior to 9/16/13). In addition to SS Director/designee overseeing that residents' SS needs are met in plan of care by assisting with CP audit reviews with CPC/DON initiated on 8/23/13, repeated ongoing when CP due between 8/23-9/15/13; additional audit assistance assured as of 9/14/13 for supplemental documentation of special needs/non-compliance issues, and other specialized SS needs to be met. (see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no other residents (other than R1/R2 alleged by said practice).

#3/4

SS Director/CPC/designee assuring Compliance by reviewing residents' chart with suspected change of condition/behaviors/grievances/care plans with weekly clinical meetings (as Nsg Clinical team share information based on 24 hour reports, MD order for change in condition/ incident reports, etc that Social Services can document as needed. Information included with weekly Quality Improvement (QI) clinical dept. heads to be transcribed onto same audit form as completed after reviewing internal/confidential quality assurance information as attending meetings as of compliance date and then additional 30 days for QA forms. DON and Nurse Managers audited residents who were at risk (14 residents) for behaviors, safety, abuse and wandering first as of survey exit 8/23/13 then all residents assured no additional allegations/similar incident examples based on above audits along with plan of care again as of 9/14/13. (see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no other residents (other than R1 alleged by said practice). Also assured during QA meetings with review of audits for skin assessments, incidents/accidents, etc. as noted below as of 9/15/13.

In addition to SS director have individual inservices as noted under #1 above, Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty. (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding behaviors/incidents that require investigation of alleged possible harm, notification of changes/policy including types of abuse/reporting/responsibilities on: 8/23/13, 8/29/13, 9/13/13 at minimum to perform rounds and check, in addition to SS and nursing staff for any incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy.

Ombudsmen/SS Director/designee gave inservices to residents/staff and/or interviewed/talked to residents/responsible party on at least following dates: both prior to and as of 8/23/13, 9/4/13, and repeated ongoing as noted in remainder of this paragraph as of 9/15/13. These are in addition to discussing at Care Plan meetings held both prior and as of date of compliance (9/16/13) regarding resident rights, assess concerns, etc. Information of resident rights also given upon admission and at least annually thereafter as well which addresses all resident rights/abuse/reporting grievances/notifications with care/etc. FYI: Ombudsmen and SS Director/designee have assured that all residents/families understand resident rights/abuse/reporting protocol/grievances as of compliance date (9/16/13). No similar grievances voiced with Ombudsman, who is in on bi-monthly basis at minimum, in addition to monthly Resident Council meetings held and assured compliance as of 9/15/16 with amount of interaction from QI team doing rounds/Ombudsmen's interviews/review of SS grievance reports/in addition to what Nursing Management performing as noted above to assure notifications/reporting has occurred as of 9/15/13. This information transcribed onto audit form that information was included with the weekly clinical meetings and QA meetings held, and initialed off as completed on form. Done weekly after survey exit and shall continue times minimum of 4 weeks on audit form for POC.

Administrator/DON/designees gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/4/13, 9/13/13. (along with individual ones to new staff/others as needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Notification requirements, and covered all issues regarding regulatory/policy requirements for duties, policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.) (In addition: facility scheduled for outside RSS consultant company to give in-service to general all staff regarding abuse/reporting/resident rights on 8/29/13,

QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected on at least weekly basis to Administrator to review and internal QA rounds tools then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to

be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit. (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days

Date of Compliance: 9/16/13

Responsible: SS Director/Administrator

Plan of Correction/Allegation of Compliance for N192 Right to Participate Planning Carc-Revise CP Sampled residents #1 and 2

Interventions responses to answers for POC questions: Not able to do/email on 2567 itself

#1) Sampled R2 no longer resides in facility as of 8/3/13 and no further changes in care plan or notifications required after discharge. Sampled R1 remains in facility as of this date. R1's Care Plan was reviewed on 8/23/13, 8/29/13, 9/13/13 and assured as of compliance date. This is also ongoing with changes in condition requiring notification/updates/etc as needed ongoing. Last time (prior to compliance date of 9/16/13) R1 has had no significant change in condition and has been reviewed by Care plan team a ongoing with new orders/Dx, etc not already on plan of care or references to Care Plan addendums. POA and chart has been updated ongoing with interventions, based on unique disease conditions, goal expectations, non-compliance issues, etc. as needed via phone to family along with both MD and Medical Director involvement at this point, in addition to SS Director and nursing staff communication to POA. (same sampled resident as noted in 9/12/13 survey exit which all of deficiencies are isolated based on R1. CP team, Speech/Physical/Occupational therapists, Medical Director, attending physician, PASSR specialist, Dermatologist, etc have all assisted facility with R1 and POA ongoing for overall plan of care expectations which are noted in R1's chart on multiple dates. POA has declined several of suggestions and have been documented accordingly throughout stay/SS notes, etc. as of compliance date.

#2 All residents have potential to be affected by said practice. No other residents identified/had any adverse effects based on alleged deficient practice. Assured via all care plans audited as of 9/14/13, along with chart/24 hr report audits/etc. Compliance also assured by CP nurses receiving new physician orders and assuring in chart (ie: MARS/TARS/Behavior sheets, etc). Care Plans have been reviewed by DON/CPC team for accuracy initiated on 8/23/13, and repeated 8/30/13, and 9/13/13 in addition to when a resident's RAI due during time frame from 8/23/13 to 9/15/13 and with changes during weekly clinical meetings for residents that were placed on nurses' 24 hour report for change in condition, incident reports, and other change in clinical factors to assure plan of care being adhered to as of compliance date.

#3/4 DON, CPC, Admin/designee assured Compliance by checking/comparing nurses' 24 hr reports, incidents, careplans and skin assessments for residents as of compliance date to assure Policy for notifying MD/POA/other agencies as needed ongoing when listed on 24 hour report, having new MD order for change in condition/notification of incident report completed, and with performing additional assessments when MDS due which includes checking treatment record which included all residents when reviewing as of compliance date. Information included with weekly Quality Improvement (QI) clinical dept. heads to be transcribed onto an audit form as completed after reviewing internal/confidential quality assurance

information. This was assured by DON/designee as of compliance date. Shall repeat QA audit form for proof of performing x 30 days. (see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no other residents (other than R1) were affected by said practice). Was also assured during QA meetings with review of audits for skin assessments, incidents/accidents, etc. as noted below as of 9/15/13.

#3/4 Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty, (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding notification of changes/policy including requirements for notification when there is an accident/incident per policy on: 8/23/13, 8/26/13, 9/13/13 at minimum to perform rounds and check, in addition to nursing staff, if any incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy. QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least weekly in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members.

Administrator/Executive Director/DON gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/9/13 and 9/13/13 (along with individual ones to new staff/others as needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Care Plans, assuring resident needs are addressed/interventions in place regardless of department if noting change in "normal" function, Notification requirements, and covered all issues regarding regulatory/policy requirements for duties, policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.)

CPC/DON(CP team) reviewed all Care plans as of 8/23/13 (after survey exit) and continued ongoing as needed when changes in care plan needed/RAI due date and repeated as of 9/13/13. Audits performed given to Administrator/designee to assure performance completed with showing number of care plans audited/when, etc as of compliance date to show all were reviewed by CP managers. Interventions/in-services, etc. have been effective regarding accuracy of care plan information being updated accordingly to individual residents' needs. This information also reported with previous/current QA meetings.

QI members (designated Dept Heads) shall document completing checklist rounds sheet which include monitoring/assuring plan of care being given, etc at least 2 times weekly to both staff member at time of rounds and to respective Dept. Head responsible for that supervisor's staff to follow up. Administrator/designee shall review and document at least weekly of completion. This information shall be discussed with both weekly department head clinical meetings for any concerns and also with QA meeting x 30 days. This includes scheduled weekend MOD (manager on duty- who is a QI member/Dept Head assigned to show monitoring/rounds performed

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit, (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days)

Date of Compliance 9/16/2013.
 Responsible: Director of Nursing/CPC

Plan of Correction/Allegation of Compliance for N316 Effective Administration/Resident Wellbeing
 (Please refer back to all previous deficient practices for specific information relating to that topic)

#1- Administrator/Chief Executive Director have reviewed all audits, in-services, monitoring (as described below for all noted deficiencies completed and compliance assured as of 9/16/13. Medical Director, and Governing Body has been given information to review to assure compliance, effectiveness of interventions and follow through if any employee (after multiple in-services) receive counseling as needed in every tag and no later than 9/14/13. Administration team (including all dept. heads) have complied with performing below audits, reporting, monitoring, and analyzing information given on daily, weekly, and monthly basis for both QI/QA for all federal and state findings. (see below). In addition facility had Risk Management come into facility 8/29/13 to assist with education in addition to QA members.

Governing Body in-serviced, discussed, duties/ monitoring of all Administration/Department Managers prior to survey exit as well as all on 8/23/13 (after survey exit), 9/4/13, 9/12/13 at a minimum regarding audit/survey compliance and QA results, need for addressing/giving inservices, assuring compliance and addressing staff regarding non-compliance after inservicing. These inservices are in addition to emailing/other forms of receiving/giving information for every Department Manager to assure verify administration performing audits/monitoring as of compliance date. (please refer to specific tags for inservices/audits, etc given to avoid repeating amount of duplicate information.)

#2- All residents have potential to be affected by said practice. Staff, residents, and all components as outlined under tags reveal compliance with adverse effects from overall systems/Administration. Staff have all been inserviced based on deficiencies noted, policies, issues.

All audits done prior to 9/16/13 and have been given to Admin/designee with weekly clinical meetings initiated as of 8/24/13 at minimum for review and include: Director of Nursing and Nurse Managers monitored MD orders and 24 hour rept. sheets to ensure MD and family members/POA notified of any changes in resident status. They are also auditing care plans/interventions and implementation of care plans to ensure that the care plan meets the needs of the resident. QI members assured resident rights regarding privacy /dignity. Social services notes to ensure the facility provide medically related social services to maintain the highest practicable level of physical, mental, and psychosocial wellbeing of each resident Administrator monitor audit reports for QI members and DON to ensure compliance with monitoring and transcribes onto QA audit form for survey team to show completion based on specific tag audits as listed under that deficiency. (General All Staff given information on 8/23/13, 8/26/13, 8/29/13, 9/13/13 for all issues notes at a minimum). Counseling next recourse after voicing understanding and numerous inservices given.

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, 13 and again after 9/13/13 survey exit. Shall be repeated additional times (not for POC, but internal purposes and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit.. All issues examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days

Date of Compliance: 9/16/2013.
 Responsible: Corp Executive Director along with Administrator