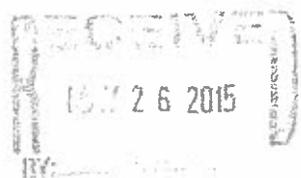


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/16/2015
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Abbreviated/Partial Extended Survey investigating KY00022995 and KY00023037 was initiated on 04/02/15 and concluded on 04/16/15. Two (2) Immediate Jeopardy situations were identified during the investigation.</p> <p>KY00022995 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 04/07/15 and determined to exit on 03/15/15 with deficiencies cited at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225 and F-226 all at a Scope and Severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.13, Resident Behavior and Facility Practice. The facility was notified of the Immediate Jeopardy on 04/07/15.</p> <p>On 03/15/15, Certified Nursing Assistant (CNA) #1, CNA #2 and Certified Medication Aide (CMA) #9 witnessed Registered Nurse (RN) #1 yelling at Resident #1. Interview and record review revealed, the three staff that witnessed the incident all identified this to be verbal abuse; however due to the lack of abuse education, did not report the incident to administration until 03/17/15 and therefore the facility failed to protect the residents, to initiate an abuse investigation, and to report the incident to the appropriate State Agencies in a timely manner.</p> <p>An acceptable credible Allegation of Compliance was received on 04/14/15, alleging removal of the Immediate Jeopardy related to abuse on 04/12/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on</p>	F 000			



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

*Michael J. [Signature]*

TITLE

ADMINISTRATOR

(X5) DATE

5/26/15

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

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F 000	<p>Continued From page 1</p> <p>04/12/15, prior to exit on 04/16/15, with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223; F-225 and F-226 all at a Scope and Severity of a "D".</p> <p>KY00023037 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 04/07/15 and determined to exist on 03/28/15 with deficiencies cited at 42 CFR 483.10 Resident Rights, F-155; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25, Quality of Care, F-309, all at a Scope and Severity of a "J"; 42 CFR 483.20, Resident Assessment, F-279 and 42 CFR 483.75 Administration, F-490 at a Scope and Severity of a "K". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care, F-309. The facility was notified of the Immediate Jeopardy on 04/07/15.</p> <p>After supervisory review 42 CFR 483.75 Administration, F-514 was also determined to exist on 03/28/15 at a Scope and Severity of a "J".</p> <p>On 03/28/15 at approximately 4:50 AM, Resident #2, who implemented Advance Directives on 03/25/15 requesting to be a Full Code, was found non-responsive by RN #1. Record review revealed, RN #1 documented Resident #2 had no pulse, no blood pressure and no signs of life; however, there was no documented evidence she immediately initiated a Full Code including the provision of cardiopulmonary resuscitation (CPR) as per the resident's Advance Directives and Physician orders. Interview with RN #1 revealed she did not initiate CPR, per the resident wishes, because he had been sick and she didn't want to desecrate his/her body anymore and she didn't want to break the resident's ribs. Interview</p>	F 000			

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F 000	Continued From page 2 revealed the facility did not have a system in place to provide routine training and/or Mock Code drills for staff to ensure proficiency in the event of a Code prior to this incident. Further interview revealed, the facility did not have a system in place to ensure at least one CPR certified staff member was in the facility at all times.  An acceptable credible Allegation of Compliance was received on 04/14/15, alleging removal of the Immediate Jeopardy related to Advance Directives and Code Status on 04/12/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on 04/12/15, prior to exit on 04/16/15, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-155; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-309; and 42 CFR 483.75, Administration, F-514 all at a Scope and Severity of a "D"; and 42 CFR 483.20 Resident Assessment, F-279 and 42 CFR 483.75, Administration, F-490 at a Scope and Severity of an "E".	F 000			
F 155 SS=J	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.  The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents	F 155	Administrator and DON reviewed Advance Directive policy, Code Status policy, Resident Right's policy, and Full Code Policy. Administrator revised Code Status Policy to include placement of a green sticker next to resident name outside room and a green bracelet on person of all "Full Code" status residents. Furthermore, Administrator created new policy titled Code Status Acknowledgement policy to instruct staff how to identify		

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F 155	<p>Continued From page 3</p> <p>concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</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 to ensure Advance Directives for one (1) of twelve (12) sampled residents (Resident #2) were honored.</p> <p>On 03/25/15, Resident #2's Responsible Party signed Advance Directives requesting the resident have a Full Code status (Full Code indicates life-saving measures were to be implemented in the event of cardiac or respiratory failure), to include Cardiopulmonary Resuscitation (CPR). However, on 03/28/15 at approximately 4:50 AM, when Registered Nurse (RN) #1 found Resident #2 unresponsive, with no pulse or respirations, the nurse failed to initiate CPR according to Resident #2's Advance Directives. RN #1 stated she was not aware of Resident #2's code status. She went to the nurse's station and had Certified Nursing Assistant (CNA) #3 and CNA #4 come to Resident #2's room with her, and they told her they thought the resident was a Full Code. However, RN #1 failed to initiate CPR, and again returned to the nurse's station to verify</p>	F 155	<p>residents' choice of "Full Code" or Do Not Resuscitate (DNR). Policy states that staff must review code status with all new residents upon admission to facility to designate wish to be "Full Code" or "DNR" and further instructs staff how identification of resident code status is communicated and documented. Policy states that "Full Code" status residents will have placement of green stickers next to resident name outside room and green bracelet place on person. "DNR" will have black sticker placed next to name outside room.</p> <p>In accordance with existing, revised, and new policies Medical Records personnel conducted a review of all current residents, as of 3/31/15, in the facility to verify code status was correct according to residents advance directives on 3/31/15. DON and ADON placed green stickers next to resident names outside rooms and green bracelets on residents with "Full Code" status on dates 3/31/15 through 4/3/15.</p> <p>All staff, except for four, were educated on revised code status policy between 3/31/15 and 4/16/15 by DON and ADON. DON and ADON</p>		

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F 155	<p>Continued From page 4</p> <p>Resident #2's code status herself. RN #1 determined Resident #2 was a Full Code, but she did not initiate CPR according to the resident's Advance Directives. Par interview, RN #1 pronounced Resident #2 deceased, notified the Physician and the resident's family, and called the funeral home.</p> <p>The facility's failure to ensure residents' Advance Directives regarding their requested Full Code status was honored has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 04/07/15, and was determined to exist on 03/28/15. The facility was notified of the Immediate Jeopardy on 04/07/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15 with the facility alleging removal of the Immediate Jeopardy on 04/12/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on 04/12/15, prior to exit on 04/16/15, with remaining non-compliance at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Advance Directives and Do Not Resuscitate Orders", undated, revealed the "Patient Self-Determination Act" mandated Medicare and Medicaid certified nursing facilities to give residents information about their right to make decisions concerning medical care, including the right to accept or refuse treatment and the right to formulate</p>	F 155	<p>conducted the education in several small group sessions during the dates 3/31/15 through 4/16/15 with open conversation and a question and answer period to ensure knowledge and understanding of the policy. The four staff members, 1 LPN and 3 CNAs, who did not receive this education, are on medical leave with an unknown date for return at this point, however, they will not be allowed on the schedule until they have completed the education that is to be conducted by DON or ADON. Furthermore, this education has been added to the facility's orientation program which is conducted prior to new employees providing direct care in the facility.</p> <p>Social Services Director will audit all "Full Code" status residents to ensure proper placement of green stickers and green bracelets weekly for 180 days then monthly thereafter. Social Services will review with each resident/ responsible party code status during Care Plan Conferences for all residents. Results of audits will be reviewed by the QAPI Committee, which includes Administrator, DON, ADON, Dietary Director, Activities Director, Housekeeping/ Laundry</p>		

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F 155	<p>Continued From page 5</p> <p>Advance Directives. Further review revealed Advance Directives referred to written documents completed by residents prior to a serious illness which noted the resident's choices about medical treatment, and was to include the name of an individual designated to make choices on the resident's behalf if the resident was unable to make decisions.</p> <p>Review of the facility's "Resident Rights" document, undated, revealed the facility would maintain written policies and procedures regarding Advance Directives, including provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an Advance Directive. Continued review revealed the facility would provide education for staff concerning its policies and procedures related to Advance Directives. Per the document, residents had a right to a dignified existence, self-determination, and communication, with access to persons and services inside and outside the facility.</p> <p>Review of the facility's policy titled, "Code Status Policy", dated July 2011, revealed the facility recognized two (2) code status options for its residents, which included a Full Code status or Do Not Resuscitate (DNR) status. Continued review revealed a Full Code status required the resident or the Responsible Party to provide written consent.</p> <p>Review of the medical record for Resident #2 revealed the facility admitted him/her on 03/25/15, with diagnoses which included Coronary Atherosclerosis, Hypertension, and</p>	F 155	Supervisor, MDS Coordinator, and Maintenance Director.	6/12/15	

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F 155	<p>Continued From page 6 status post Myocardial Infarct (heart attack), Coronary Artery Bypass Graft (open-heart surgery), and aftercare for a healing Traumatic Fracture of the Hip.</p> <p>Review of Resident #2's "Admit/Readmit Screener", dated 03/27/15, revealed Resident #2 was the reporter (person providing the information) for this assessment. Further review revealed Resident #2 was alert to person and appropriate verbally. Review of the "Code Status Consent Form", dated 03/25/15, revealed it was signed by the resident's Responsible Party on 03/25/15. Continued review of the Form revealed it stated to "observe the attending Physician's Order and in the case of death" of Resident #2, "USE cardiac compressions or artificial ventilation to resuscitate".</p> <p>Review of the Physician's Orders, dated 03/25/15, revealed Resident #2 had an order for a Full Code status. Review of the March 2015 Electronic Medication Administration Record (e-MAR) and Electronic Medication Treatment Record (e-TAR) revealed Resident #2 was a Full Code status.</p> <p>However, review of the Nurse's Note, dated 03/28/15 at 4:50 AM, signed by RN #1, revealed she had found Resident #2 lying in bed with no pulse, no blood pressure and no signs of life. Continued review revealed no documented evidence RN #1 immediately initiated CPR according to Resident #2's Advance Directive. Additional review of the Nurse's Notes revealed RN #1 notified the Physician at 5:05 AM, the family at 5:10 AM, and the funeral home at an unstated time. Review of the "Provisional Report of Death" form revealed Resident #2's date of</p>	F 155		

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F 155	<p>Continued From page 7</p> <p>death was documented as 03/28/15, with the time noted to be 4:50 AM.</p> <p>Interview, on 04/04/15 at 3:26 PM, with RN #1 revealed she was the Charge Nurse, and the primary nurse for Resident #2, on the night shift of 03/28/15. Per interview, she was certified to perform CPR; however, when she found Resident #2 on 03/28/15 at 4:50 AM, she did not initiate CPR. She stated she left Resident #2's room and went to the nurse's station to request assistance from the CNAs. RN #1 stated the CNAs told her they thought Resident #2 was a Full Code, but she did not initiate CPR again and returned to the nurse's station to verify the resident's code status. RN #2 stated she noted Resident #2 was a Full Code; however, when she returned to the resident's room she once again did not initiate CPR, as per the resident's Advance Directives. According to RN #1, she instructed the CNAs to provide post-mortem care of Resident #2's body instead. Continued interview revealed the CNAs reported to her that during the provision of post-mortem care they thought they had felt a heart beat, and thought they saw Resident #2 take a breath. She stated she listened for heart sounds with a stethoscope and found none, and again did not initiate CPR. Per interview, RN #1 stated if residents were sick and had already had heart surgery, "where do you draw the line?". RN #1 further stated she did not want to break Resident #2's ribs by performing CPR, did not want to "desecrate" the resident's body, and she felt CPR was "futile".</p> <p>Interview with CNA #4, on 04/06/15 at 8:00 PM, revealed she was working on 03/28/15, and was assigned to care for Resident #2. She stated a little before 5:00 AM, RN #1 came to the nurse's</p>	F 155			

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F 155	Continued From page 8 station where she and CNA #3 were charting, and asked for help with Resident #2. CNA #4 reported upon entering Resident #2's room she observed the resident to be "yellow" in color, and she asked the RN if the resident was still alive. Continued interview revealed RN #1 told CNA #4 she didn't think so and to go check the resident's chart for his/her code status. CNA #4 revealed Resident #2's chart was checked and it was determined the resident was to have a Full Code status which was reported to RN #1. According to CNA #4, after RN #1 was told this information, she did not initiate CPR. Further interview revealed RN #1 told CNA #4 the resident was already gone and she didn't want to break his/her ribs, and instructed the CNAs to perform post-mortem care. Per interview, during the post-mortem care CNA #4 thought she saw Resident #2 take a breath which she reported to RN #1. The CNA stated RN #1 did not initiate CPR for Resident #1; however, she did listen for a heart beat with a stethoscope and didn't hear anything.  Interview, on 04/06/15 at 8:20 PM, with CNA #3 revealed on 03/28/15 she and CNA #4 were sitting at the nurse's station charting early in the morning. RN #1 came to them at the nurse's station and requested assistance from her and CNA #4. She stated CNA #4, RN #1 and she went to Resident #2's room, and when CNA #4 saw the resident she asked RN #1 if the resident was alive, and RN #1 stated she didn't think so. Continued interview revealed RN #1 asked the CNAs to go check the resident's chart to verify Resident #2's code status. Per interview, she and CNA #4 checked Resident #2's chart and determined the resident was a Full Code, which CNA #3 reported to RN #1 and told the nurse she	F 155			

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F 155	<p>Continued From page 9</p> <p>needed to initiate CPR immediately. According to CNA #3, RN #1 told the CNAs she wasn't going to break the resident's ribs by performing CPR, and RN #1 did not initiate CPR for Resident #2. She stated RN #1 instructed them to perform post-mortem care for Resident #2, and during the post-mortem care CNA #3 thought she felt a pulse. Per CNA #3, she reported this information to RN #1, who listened for a heartbeat with a stethoscope but didn't hear anything. CNA #3 stated CPR was never initiated for Resident #2. Further interview with CNA #3 revealed she was not CPR certified and if she found an unresponsive resident she was to report this information to the nurse.</p> <p>Interview, on 04/02/15 at 11:40 AM, with the Director of Nursing (DON) revealed RN #1 left her a voice message on her cellular telephone (cell phone) on 03/28/15 around 4:50 AM, telling her Resident #2 had expired. Continued interview revealed she talked to RN #1, on 03/28/15 around 11:30 AM, RN #1 reported she had not initiated CPR because Resident #2 had no respirations, no pulse, had already expired and she (RN #1) did not want to break the resident's ribs by doing CPR. The DON stated the facility did not have specific procedures in the event of the death of a resident who had a Full Code status, but she expected CPR would be initiated immediately and "911" notified for transporting the resident to the hospital. Per interview, RN #1 should have initiated CPR immediately for Resident #2, but this was not done.</p> <p>Interview, on 04/06/15 at 11:53 AM, with the Administrator revealed he expected the licensed nurses to know which residents had Full Code</p>	F 155			

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NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
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F 155	<p>Continued From page 10</p> <p>status, and to initiate CPR immediately for any "Full Code" resident found to be unresponsive and without signs of life. Continued interview revealed RN #1 should have initiated CPR immediately when Resident #2 was found unresponsive and it was determined he had Full Code status.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15, which alleged removal of the IJ effective 04/12/15. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> <li>1. On 03/28/15, the Director of Nursing (DON) initiated an investigation into the incident involving Resident #2. The DON interviewed (Registered Nurse) RN #1, Certified Nursing Assistant (CNA) #3 and CNA #4 regarding Resident #2 not receiving Cardiopulmonary Resuscitation (CPR) even though the resident was Full Code status. RN #1 was suspended pending the facility's investigation. On 03/30/15, an initial report of the incident involving Resident #2 on 03/28/15 was sent to the State Agency by the Social Services Director.</li> <li>2. On 03/30/15, RN #1 was terminated from her position of employment with the facility.</li> <li>3. On 03/30/15, the facility developed a Code Status Acknowledgement policy which included the procedure for a visual identification system. Full Code status residents would be identified by application of a green bracelet to the resident's wrist, and placement of a green sticker outside the resident's door beside their name. A resident with a Do Not Resuscitate (DNR) status would have a black sticker on the door by their name.</li> </ol>	F 155			

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F 155	Continued From page 11  4. On 03/31/15, the DON and the Assistant DON (ADON) conducted education in small group sessions to all staff (with the exception of four (4) staff on medical leave) related to their knowledge and understanding of the facility's Code Status Acknowledgement policy. Education related to the Code Status Acknowledgement policy was added to the training agenda for New Employee Orientation.  5. On 03/31/15, Medical Records personnel conducted a review of all current residents in the facility to verify their code status.  6. On 03/31/15 through 04/01/15, the Social Services Director (SSD) reviewed Advance Directives with all current "Full Code" status residents and/or their Power of Attorney (POA) to ensure their code status was accurate.  7. On 04/01/15, the SSD verified the Code Status Acknowledgement policy was implemented by a visual inspection of all full code status residents to ensure each had a green bracelet on their wrist and a green sticker next to their name on the door.  8. The SSD monitored daily beginning 04/01/15 through 04/11/15, to ensure all full code status residents continued to wear a green bracelet and had a green sticker next to their name on the outside of their door.  9. On 04/06/15 through 04/11/15, the Administrator and the DON made daily rounds through the facility on all shifts to question and talk with staff about the new Code Status policy.	F 155			

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F 155	<p>Continued From page 12</p> <p>10. On 04/07/15, the Administrator educated the Minimum Data Set (MDS) staff related to resident's code status documented on the resident's Comprehensive Care Plan (CCP) and it was to be reviewed at the resident Care Plan Conferences.</p> <p>11. On 04/07/15, MDS staff conferred with Medical Records staff to verify each residents' code status was correct. The MDS staff revised all resident CCPs to reflect each resident's Advance Directives.</p> <p>12. On 04/07/15, the Code Status Policy was revised to incorporate instructions to add code status to resident CCPs on admission.</p> <p>13. Beginning 04/15/15, the SSD will review code status with all the residents and/or their POA during resident Care Plan Conferences.</p> <p>14. On 04/07/15, the DON audited all licensed Charge Nurse's personnel files for the presence of current CPR certifications, and found two (2) who were not current. On 04/08/15, all licensed nurses were instructed to have current CPR certification by 04/10/15.</p> <p>15. On 04/08/15, the Administrator implemented a CPR policy and a Code 500 Policy. On 04/08/15, the Administrator provided education to the DON and the ADON related to the new CPR and Code 500 policies.</p> <p>16. On 04/08/15 through 04/11/15 the DON and the ADON conducted education with all staff related to the CPR, Code Status, Code Status Acknowledgement and Code 500 policies and General Documentation Guidelines for CPR, with</p>	F 155			

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F 155	<p>Continued From page 13</p> <p>post-education tests implemented on 04/10/15, to ensure the staff's knowledge and understanding of the policies.</p> <p>17. On 04/09/15, the Administrator audited all current resident charts to verify the code status was on each resident's CCP, with no issues identified.</p> <p>18. The DON will audit new hire nursing staff for CPR certification expiration dates and will schedule CPR certification courses as necessary to ensure all charge nurses maintained CPR certifications.</p> <p>19. On 04/10/15, the Administrator audited all nurses' personnel files to ensure all were CPR certified as instructed on 04/08/15. No issues were identified and the Administrator will continue to verify the DON audits of Charge Nurse's personnel files to ensure they maintain CPR certification.</p> <p>20. On 04/10/15, the Administrator audited the current facility schedule to verify a CPR certified staff member was present in the facility at all times. The Administrator will continue to audit the nurse schedule monthly, and when changes occur, to ensure all shifts are staffed with a CPR certified nurse.</p> <p>21. On 04/10/15, the Administrator, the DON and the ADON conducted a Mock Code 500 drill and reviewed findings after completion with staff who responded to the drill. The facility will conduct Mock Code 500 drills on a weekly basis for the next sixty (60) days, on different days and shifts. The Administrator and the DON will monitor Code 500 documentation for completeness and</p>	F 155			

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F 155	<p>Continued From page 14 accuracy.</p> <p>22. On 04/10/15, the Administrator notified the Medical Director of the code policy revisions.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the facility's investigation of the incident revealed RN #1, CNA #3 and CNA #4 were interviewed related to the Code 500 event involving Resident #2. Continued review of the investigations revealed, RN #1 was suspended on 03/28/15, pending the investigation results. Per review, the initial report was sent to the State Survey Agency regarding the Code event involving Resident #2 on 03/30/15, and it was signed by the SSD.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed she had initiated the investigation on 03/28/15, and interviewed the staff involved (RN #1, CNA #3 and CNA #4). Per interview, RN #1 was suspended from work pending the results of the investigation. The DON stated the SSD sent the initial report of the incident to the State Survey Agency on 03/30/15.</p> <p>2. Review of RN #1's personnel file verified she was terminated from her employment at the facility. Interview with RN #1 on 04/04/15 at 3:26 PM, confirmed her employment at the facility was terminated on 03/30/15.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed RN #1's employment was terminated on 03/30/15.</p> <p>3. Review of the facility's Code Status</p>	F 155			

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F 155	<p>Continued From page 15</p> <p>Acknowledgement policy, dated 03/30/15, and revised 04/09/15, revealed it included the procedure for visual identification of a resident's code status. Per the Policy, Full Code status residents would wear a green bracelet on their wrist and have a green sticker located outside the room door by their name.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed the facility's Code Status Acknowledgement policy now included the procedure for visual identification of a resident's code status through Full Code residents wearing a green bracelet on their wrist and a green sticker placed by the resident's name outside their room door.</p> <p>4. The facility's CPR policy and Code 500 policy, Code Status policy and Code Status Acknowledgement policy were reviewed. Review of the facility's in-service sign-in forms dated 03/31/15, revealed staff was educated on the facility's Code Status Acknowledgement policy and the other code related policies. Review of the facility's New Employee Education Pack revealed the Code Status Acknowledgement policy education had been added.</p> <p>Interview on 04/06/15 at 8:00 AM with CNA #4; at 8:20 AM with CNA#3; at 12:38 PM with LPN #6; at 1:58 PM with CNA #5; at 2:00 PM with CNA #6; at 3:55 PM with CNA #11; and, at 4:05 PM with LPN #7 revealed they had all been provided education related to the facility's Code Status Acknowledgement Policy between 03/31/15 and 04/11/15, in small group sessions.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed the education on the Code Status</p>	F 155			

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F 155	<p>Continued From page 16</p> <p>Acknowledgement policy had been provided as per the AOC, with all but four (4) staff receiving the education. The DON stated the four (4) staff who had not receive the education were on medical leave, but would not be put on the schedule to work until they had received the education. Per interview, the education was added to the new hire orientation training agenda.</p> <p>5. Review of the Medical Records documentation related to the verification of all residents' code status, revealed all residents' code status was verified.</p> <p>Interview with the DON, on 04/16/15 at 2:26 PM, revealed after Medical Records compiled the code status information, she verified it with comparison to the residents' written signed consents.</p> <p>6. Review of the documentation of the SSD's Advance Directives review with all current "Full Code" status residents and/or their POAs to ensure the code was accurate revealed the code status was verified for each resident from 03/31/15 through 04/01/15.</p> <p>Interview, on 04/02/15 at 1:20 PM, with Resident #3 revealed his/her daughter was the resident's POA and talked to staff about decisions regarding his/her care; however, a green bracelet (indicated a Full Code status) had been placed on him/her on 04/01/15. Interview, on 04/15/15 at 11:07 AM, with Resident #9 revealed the SSD had talked to the resident about his/her "Full Code" status. Interview, on 04/14/15 at 12:24 PM, with Resident #10 revealed the SSD had discussed the resident's "Full Code" status with him/her and he/she had made the decision to have the code</p>	F 155		

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F 155	<p>Continued From page 17</p> <p>status changed to a DNR. Interview, on 04/14/15 at 12:45 PM, with Resident #8 revealed the resident thought someone had talked with him/her about Advance Directives; however, he/she could not recall who had talked to him/her. Resident #8 revealed he/she was not aware of what his/her Advance Directive or code status was at this time.</p> <p>Interview, on 04/16/15 at 1:06 PM, with the SSD revealed she had conducted the Advance Directives review with "Full Code" status residents and/or their POA to verify the code status was accurate. The SSD revealed if a resident requested to change their status, it was changed as requested.</p> <p>7. Review of documentation of the check off sheet, dated 04/01/15, revealed the SSD had verified all Full Code status residents had a green bracelet on their wrist and a green sticker next to their name on their door.</p> <p>Observation revealed eleven (11) of eleven (11) residents, who were "Full Code" status, were wearing a green bracelet and had a green sticker outside the room door by their name.</p> <p>Interview, on 04/16/15 at 1:06 PM, with the SSD revealed she had conducted a visual inspection of all "Full Code" residents on 04/01/15 to ensure the Code Status Acknowledgement policy had been implemented. Per the SSD, she verified all the "Full Code" status residents were wearing a green bracelet and a green sticker was by the resident's name outside their room door.</p> <p>8. The computer generated "Full Code" status logs utilized by the SSD to monitor that all "Full</p>	F 155			

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F 155	<p>Continued From page 18</p> <p>Code" status residents had a green sticker on their door by their name and was wearing a green bracelet. The review revealed the SSD's "Full Code" status log had been checked and signed by the Administrator on 04/10/15, to verify the log had been completed by the SSD.</p> <p>Interview, on 04/16/15 at 1:08 PM, with the SSD revealed she had conducted the monitoring beginning 04/01/15 through 04/11/15, to ensure residents had the green bracelet on if they had a "Full Code" status, and to ensure the green sticker was beside their names outside their room doors.</p> <p>Interview, on 04/16/15 at 3:00 PM, with Administrator revealed he had reviewed the SSD log and verified the SSD had completed the monitoring to ensure "Full Code" status residents had their green bracelet in place and the green sticker was beside their name outside the room door.</p> <p>9. Reviewed the Administrator's and DON's daily rounds log sheet dated 04/06/15 through 04/11/15, which revealed the rounds were made each day on all shifts. Reviewed the documentation of the educational questions and answers that were reviewed with staff.</p> <p>Interview, on 04/15/15: at 11:45 AM with RN #4; at 1:20 PM with CNA #12; at 1:25 PM with House Keeper #14; at 1:30 PM with Dietary #15; at 1:40 PM with LPN #6; at 1:50 PM with LPN #1; at 2:10 PM with LPN #8; at 2:20 PM with CNA #13; at 3:40 PM with CNA #4; at 3:50 PM with CNA #11; at 7:10 PM with LPN #9; at 7:20 PM with RN #5; at 10:05 PM with CNA #3; at 10:19 PM with CNA #4; at 10:25 PM with CNA #17; and, at 10:30 PM</p>	F 155			

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F 155	<p>Continued From page 19</p> <p>with CNA #18, the Administrator and DON had been completing rounds on each shift questioning and educating staff about codes and the facility's code status policies.</p> <p>Interview with the DON, on 04/16/15 at 2:28 PM and at 3:00 PM with the Administrator, revealed they had conducted the daily rounds throughout the facility on all shifts to question and talk with staff about the facility's Code Status policy. They stated they had ensured staff understood the new policy with no problems identified. Per interview, the results of the daily rounds would be taken to the facility's Quality Assurance/Performance Improvement (QA/PI) Committee, and any issues discussed with development of a plan to correct the problem.</p> <p>10. Reviewed the education given to the MDS staff by the Administrator related to ensuring residents' code status was documented on the CCP and that the code status was to be reviewed at residents' care plan conferences.</p> <p>Interview with the MDS Coordinator on 04/16/15 at 3:05 PM, revealed the education had been provided by the Administrator regarding residents' code status being on the care plan and ensuring the code status was discussed in the residents' care plan meetings.</p> <p>11. Reviewed 100% of the facility's residents' CCPs which revealed each resident's code status was care planned with interventions.</p> <p>Interview with the MDS Coordinator on 04/16/15 at 3:05 PM, revealed MDS staff had talked to the Medical Records staff to verify each resident's code status was correct. Per interview, MDS staff</p>	F 155			

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F 155	<p>Continued From page 20</p> <p>revised all resident's CCPs to address each resident's Advance Directives including the code status.</p> <p>12. Reviewed the Code Status Policy which revealed it had been revised April 2015, and included ensuring each resident's CCP included the code status be incorporated on admission. Reviewed the facility's "Admission Checklist for Nursing" form which revealed it included the information for nurse's to obtain an order for the new resident's code status, place the appropriate sticker on the resident's nameplate, place a green bracelet on "Full Code" residents and ensure the code status was added to the resident's care plan.</p> <p>Interview, on 04/16/15 at 3:00 PM, with Administrator revealed the facility's Code Status Policy had been revised as per the AOC.</p> <p>13. Reviewed Care Plan Conference notes, dated 04/15/15, which included reviewing the resident's "Code Status" at the planned Care Plan Conferences.</p> <p>Interview, on 04/16/15 at 1:06 PM, with the SSD revealed residents' code status was being discussed at care plan conferences which began on 04/15/15.</p> <p>14. On 04/16/15, the "Employee Roster Report" listing of all licensed staff with CPR expiration dates and copies of their CPR certification was reviewed. Reviewed the CPR certification class roster and certification cards from classes provided by the facility on 04/09/15 and 04/10/15. Review of the documentation revealed all licensed nursing staff now had current CPR</p>	F 155			

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F 155	<p>Continued From page 21 certification.</p> <p>15. Reviewed the facility's CPR and Code 500 policies. Reviewed the sign in sheet and education provided by the Administrator to the DON and ADON related to the CPR and Code 500 Policy dated 04/08/15.</p> <p>Interview with the DON and ADON, on 04/16/15 at 2:26 PM, revealed they had been educated by the Administrator on 04/08/15, regarding the CPR and Code 500 policies.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed the facility's CPR and Code 500 policies had been implemented on 04/08/15, as per the AOC. A post-survey interview on 05/01/15 at 9:32 AM, with the Administrator revealed after becoming aware of the need to have someone CPR certified in the building at all times, he had read the regulatory requirements and conferenced with the Consultant Administrator for guidance. Per interview, the Consultant Administrator had discussed with him getting staff CPR certified and what needed to be done to ensure this was done. The Administrator stated he and the Consultant Administrator had communication "all the way through" the process and had developed the plan of action.</p> <p>16. Reviewed the sign-in sheets and education provided by the DON and ADON for all staff related to the CPR and Code 500 Policy, dated 04/08/15 through 04/11/15 and reviewed the post-tests.</p> <p>Interview, on 04/15/15: at 11:45 AM with RN #4; at 1:20 PM with CNA #12; at 1:25 PM with House</p>	F 155			

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F 155	<p>Continued From page 22</p> <p>Keeping #14; at 1:30 PM with Dietary #15; at 1:40 PM with LPN #6; at 1:50 PM with LPN #1; at 2:10 PM with LPN #8; at 2:20 PM with CNA #13; at 3:40 PM with CNA #4; at 3:50 PM with CNA #11; at 7:10 PM with LPN #9; at 7:20 PM with RN #5; at 10:05 PM with CNA #3; at 10:19 PM with CNA #4; at 10:25 PM with CNA #17; and, at 10:30 PM with CNA #18 revealed they had all been educated on the CPR and Code 500 policies, and other code policies and General Documentation Guidelines for CPR, and had taken a post-test after the education.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed all but four (4) staff had received the education on the facility's code policies and CPR policy. The DON stated the four (4) staff who had not received the education were on medical leave, but would not be put on the schedule to work until they had received the education. Per interview, the education was added to the new hire orientation training agenda.</p> <p>Interview, on 04/16/15 at 3:00 PM, with Administrator revealed facility staff had been educated on the CPR, Code 500 and other code policies, as per the AOC.</p> <p>17. Reviewed the Administrator's audits of all resident's CCP for verification that each residents' code status was care planned. The audits revealed each resident had a "Code Status" CCP with no issues identified and the Administrator had signed the audits as completed on 04/09/15.</p> <p>Interview, on 04/16/15 at 3:00 PM, with Administrator revealed he had completed the audit of all residents' CCPs on 04/09/15, with no problems noted, as per the AOC. Per interview,</p>	F 155	

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F 155	<p>Continued From page 23</p> <p>the results of the audits would be taken to the facility's Quality Assurance/Performance Improvement (QA/PI) Committee, and any issues discussed with development of a plan to correct the problem.</p> <p>18. Interview, on 04/16/15 at 2:26 PM, with the DON revealed she would audit all newly hired nursing staff for their CPR certification expiration dates. Per interview, she would schedule CPR certification courses as necessary to make sure the Charge Nurses all maintained their CPR certification.</p> <p>19. Reviewed the Administrator's audits, performed on 04/10/15, of all nurses' personnel files to ensure they were CPR certified. The audits revealed each licensed staff's CPR certification was present with the expiration date, and no issues were identified by the Administrator.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed he had performed the audits of all nurses' personnel files for CPR certification on 04/10/15, and had not identified a problem. The Administrator revealed he would continue to monitor the DON's verification of the Charge Nurse's CPR certification to ensure they maintained current CPR certification. Per interview, the results of the audits would be taken to the facility's Quality Assurance/Performance Improvement (QA/PI) Committee, and any issues discussed with development of a plan to correct the problem.</p> <p>20. Reviewed the Administrator's audit of the current facility schedule verifying a CPR certified staff member was present in the facility at all</p>	F 155			

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F 155	<p>Continued From page 24 times, dated 04/10/15.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed he had completed the audit of the facility's current schedule to verify a CPR certified staff member was present in the facility at all times on 04/10/15. He revealed he would continue to monitor the nursing schedule monthly to ensure all shifts were staffed with a CPR certified nurse. Per interview, the results of the audits would be taken to the facility's Quality Assurance/Performance Improvement (QA/PI) Committee, and any issues discussed with development of a plan to correct the problem.</p> <p>21. Reviewed the sign in sheet and notes for the Mock Code Drill, conducted on 04/10/15.</p> <p>Interview on 04/15/15: at 11:45 AM with RN #4; at 1:40 PM with LPN #6; at 1:50 PM with LPN #1; and, at 2:10 PM with LPN #8 revealed the Mock Code Drill had been completed by the facility, and the findings had been reviewed with staff and allowed for staff input.</p> <p>Interview, on 04/16/15 at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed the Mock Code Drill had been completed on 04/10/15, as per the AOC. They stated the results had been discussed with staff afterwards. The Administrator and DON revealed the facility would continue to conduct Mock Code Drills weekly for sixty (60) days on different days and shifts, and they would monitor the documentation of the drills for accuracy and completeness, as per the AOC.</p> <p>22. Interview, on 04/16/15 at 1:20 PM, with the Medical Director revealed the facility had notified</p>	F 155			

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F 155	Continued From page 25 him of the Immediate Jeopardy and findings. Per interview, he had also been notified of the changes made to the facility's code policies and the new system for identification of "Full Code" residents.	F 155			
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and investigation, it was determined the facility failed to have an effective system to ensure each resident remained free from abuse for two (2) of twelve (12) sampled residents (Residents #1 and #5).  On 03/15/15 at approximately 7:00 PM, Registered Nurse (RN) #2 was overheard by staff present in the area, Certified Nursing Assistant (CNA) #1, CNA #7 and Certified Medication Aide (CMA) #9, to be yelling at Resident #1 for him/her to stop coughing in her face. Interview with Resident #1 revealed a nurse did yell at him/her to stop coughing in her face; however, he/she couldn't control the cough. Interview with Resident #5, who resided in a room near Resident #1, overheard RN #2 in the hallway on 03/15/15, stating, "I wish all you MF's would die".	F 223	DON counseled CNA #1, CNA #7, and CMA #9, on 3/18/15, individually and educated each that all staff is to report abuse immediately to supervisor. DON also educated each that if they could not report to supervisor that they should call Administrator, DON, or Social Worker and provided contact information as well. On 3/18/15 Social Worker, Administrator, and DON spoke with Resident #1 regarding allegation. Resident stated feeling safe at this time. On 3/20/15, Social Worker conducted a survey of residents with BIMS of 8 or higher. Resident #5 answered survey in "Yes" to question "Do you feel safe at facility?" On 4/8/15, Administrator conducted a review of Abuse Prevention policy with DON and Social Worker. Administrator educated DON and Social Worker that all alleged abuse allegations needed to be reported to appropriate State Agencies immediately per facility policy.		

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F 223	<p>Continued From page 26</p> <p>Interview with CNA #1, CNA #7 and CMA #9 revealed they thought what they had witnessed and overheard RN #2, the Charge Nurse, say and do was abuse. However, the three (3) staff failed to report the abuse incident immediately, as per the facility's abuse policy. Therefore, RN #2 was allowed to continue working the remainder of her shift on 03/15/15, approximately ten (10) hours caring for residents. The incident was not reported to the facility until the evening shift on 03/17/15 when CNA #1 called the Director of Nursing to report it, and RN #2 was suspended by the facility on 03/18/15.</p> <p>The facility's failure to have an effective system in place to ensure each resident remained free from abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 04/07/15 and determined to exist on 03/15/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15 with the facility alleging removal of the Immediate Jeopardy on 04/12/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on 04/12/15, prior to exit on 04/16/15, with remaining non-compliance at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse Prevention Plan", revised June 2013, revealed</p>	F 223	<p>On 3/20/15, Social Worker conducted a survey of residents with a Brief Interview for Mental Status (BIMS) score of eight and higher for possible abuse allegations of RN #2. No responses indicated further abuse allegations. DON interviewed staff working on dates 3/15/15 through 3/17/15 to identify behavioral changes of residents with BIMS scores less than eight that occurred during those dates that might indicate abuse had occurred. No signs or symptoms reported as evidence of abuse.</p> <p>All staff, except for four, were educated on facility Abuse Prevention Policy by Social Worker. One LPN and three CNAs are currently on medical leave with unknown return dates; however, they will not be allowed to be placed on the schedule until they each have completed the required education with the Social Worker. The education was conducted on dates 4/8/15 through 4/16/15 by Social Worker. On 4/8/15, Administrator met with Social Worker to review Abuse Prevention Policy to ensure she was fully aware of policy. Social Worker educated staff as part of in service on procedures required</p>	

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F 223	<p>Continued From page 27</p> <p>verbal abuse was the use of oral, written, or gestured language which willfully included disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of age, ability to comprehend, or disability.</p> <p>Review of the facility's policy titled, "Resident Rights", revised August 2013, revealed residents had a right to a dignified existence, self determination, and communication with persons and services inside and outside the facility. Per the Policy, the facility must protect and promote the rights of each resident including the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>Review of the facility's, "Resident Abuse Investigation Report Form", signed by the Social Services Director (SSD) on 03/20/15, revealed an incident had occurred on 03/15/15 around 7:30 PM, involving Resident #1, which was witnessed by three (3) staff members, CNA #1, CNA #7 and CMA #9. Continued review revealed, on 03/15/15, CNA #1 had reported RN #2 yelled at Resident #1 "Do not cough in my face" and "I can't take you coughing in my face" which the CNA did not report until 03/17/15. Per the Form, CNA #1 reported RN #2 told her she hated "him", Resident #1, and all of the facility's residents. Further review revealed RN #2 was suspended during the facility's investigation on 03/18/15. In addition, the investigation revealed both verbal and emotional abuse was substantiated.</p> <p>1. Record review revealed the facility admitted Resident #1 on 02/10/15, with diagnoses which included Confusional Arousals (a sleep disorder</p>	F 223	<p>when an abuse allegation involves an employee. Social Worker educated that the policy requires staff to walk employee to time clock and escort the employee out of facility, the resident should be placed on 1 on 1 care to ensure safety, and Social Worker, Administrator, or DON should then be contacted for further instructions. At the end of the education sessions all staff were also required to complete a post education test to determine knowledge and understanding of the policy. Employees were required to score ninety percent to pass. All staff that did not score ninety percent were reeducated and retested. The test included questions that asked when abuse should be reported, to whom, and types of abuse. Activities staff put up an abuse prevention bulletin board in the employee break room which includes when to report, to whom, and types of abuse with indicators of each type of abuse on 4/10/15. New hire orientation has been revised to include post abuse education testing prior to new staff providing beginning orientation to their respective departments. This revision is effective as of 4/8/15 with first staff orientation date on 4/27/15.</p>

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F 223	<p>Continued From page 28</p> <p>causing a person to act strangely and confused as they are waking up or just after awakening), Cerebral Embolism with Cerebral Infarction, Diabetes, Depressive Disorder, Parkinsonism and a history of Pneumonia and Cough. Review of the Admission Minimum Data Set (MDS) Assessment, dated 02/19/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating the resident was cognitively intact.</p> <p>Continued record review revealed Resident #1 was diagnosed with an Upper Respiratory Infection (URI) on 02/27/15, with orders received for an antibiotic two (2) times a day for congestion, nasal drainage and cough until 03/06/15. Further record review revealed Resident #1 continued to have a cough after completion of the antibiotic on 03/06/15, and orders were received for a cough syrup as needed (PRN) for the cough on 03/07/15, nebulizer (neb) treatments and Tessalon Perles (a non-narcotic cough medicine) on 03/16/15, and on 03/17/15 a chest x-ray was ordered due to the medications being ineffective.</p> <p>Review of the Nurse's Notes for Resident #1, revealed the resident continued to have a cough which was not relieved by the medication. Further review of the Notes revealed no documented evidence of entries made related to the incident which occurred on 03/15/15.</p> <p>Interview with Resident #1, on 04/07/15 at 2:40 PM, revealed a nurse did "yell" at him/her for coughing in her face; however Resident #1 reported, he/she couldn't help it, and "another nurse helped me".</p>	F 223	<p>Administrator will review all abuse allegations to monitor for implementation of policy. Social Worker will conduct an audit of all staff regarding knowledge and understanding of Abuse Prevention policy weekly for 60 days, monthly for 120 days, bi-monthly for 120 days, and then quarterly thereafter. Social Worker will conduct audit by utilizing questionnaires covering types of abuse, signs and symptoms of abuse, reporting of abuse, and facility policies and procedures regarding abuse. Audits will be conducted on all shifts Monday through Sunday. Social Worker will immediately conduct retraining as needed for staff which does not display knowledge and understanding of Abuse Prevention policy. Social Worker will report all concerns and any need for retraining to the QAPI Committee. The Administrator will report all concerns regarding implementation of policy will be taken to QAPI Committee for further investigation and resolution.</p> <p style="text-align: right;">6/12/15</p>

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F 223	<p>Continued From page 29</p> <p>2. Review of Resident #5's medical record revealed the facility admitted the resident on 03/16/11, and readmitted on 09/11/13, with diagnoses which included Chronic Airway Obstruction, Depression, Congestive Heart Failure, Insomnia, Anxiety and Debility. Review of the Quarterly MDS Assessment, dated 02/02/15, revealed the facility assessed Resident #5 as being cognitively intact, with a BIMS score of fifteen (15) out of fifteen (15).</p> <p>Interview, on 04/02/15 at 1:00 PM, with Resident #5, who resided near Resident #1, revealed on 03/15/15, RN #2 was in the hallway and the resident overheard the RN saying, "I wish all you MF's would die". Continued interview revealed some of the CNAs were present when RN #2 made the comment and the RN's comment made Resident #5 mad.</p> <p>Review of the facility's investigation report documentation of RN #2's written statement, undated, revealed on "Sunday" (03/15/15) she had walked by Resident #1's throughout the night, and looked in on the resident. Continued review of RN #2's written statement revealed at 4:00 AM to 5:00 AM on 03/16/15, she "noticed" Resident #1 was "trying to cough up stuff", and she entered the resident's room and handed him/her a tissue "to try and bring up something" for her. Further review of RN #2's written statement revealed no documented evidence she addressed the allegation of abuse.</p> <p>Review of (RN) #2's time sheet, for the week of 03/15/15 to 03/28/15, revealed RN #2 worked from 5:30 PM on 03/15/15 until 03/16/15 at 6:49 AM.</p>	F 223			

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F 223	Continued From page 30  Interview with RN #2, on 04/07/15 at 1:50 PM, revealed she stated "nothing happened" on 03/15/15, and she reported being hard of hearing and had a sinus infection at the time. Continued interview revealed RN #2 denied making any comments regarding hating residents and wishing they would all die. Per interview, she would never make a comment like that to a resident or where a resident could hear her. However she stated she had an "off the wall" sense of humor and might have said things to other staff.  Interview, on 04/07/15 at 4:30 PM, with CNA #1, revealed on 03/15/15 around 7:30 PM, she witnessed an incident involving Resident #1. Per interview, CNA #1 heard RN #2 state she (RN #2) hated Resident #1 and all of the facility's other residents. CNA #1 revealed she also heard RN #2 yelling at Resident #1 to stop coughing in her face because she (RN #2) couldn't stand it. Continued interview revealed CNA #1 considered what she had witnessed RN #2 say to Resident #1 as verbal abuse; however, she did not immediately report the abuse, as RN #2 was the Charge Nurse and she had been trained to report the abuse to the Charge Nurse.  Interview, on 04/07/15 at 4:20 PM, with CNA #7 revealed on 03/15/15 around 7:30 PM, she was standing in the hallway and overheard RN #2 yelling at Resident #1 to stop coughing in her face. Per interview, after RN #2 left Resident #1's room, she heard RN #2 state she hated all the residents and she was not a "people person". CNA #7 revealed she considered what she had witnessed to be verbal abuse; however, she did not immediately report the abuse. Continued interview revealed she didn't know who to report	F 223			

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F 223	<p>Continued From page 31</p> <p>the abuse to because the education she had received in orientation covered the types of abuse and that she was to report allegations to the Charge Nurse.</p> <p>Interview, on 04/07/15 at 2:30 PM, with CMA #9 revealed she had witnessed RN #2 yelling at Resident #1 on 03/15/15 to stop coughing in her face. Per interview, she felt what she had witnessed on 03/15/15 was verbal abuse; however, did not report the abuse because the CNA's had witnessed the whole incident and she thought they were going to report it.</p> <p>Interview with the DON, on 04/02/15 at 11:40 AM, revealed CNA #1 called her at her home, on her cellular phone (cell phone) on 03/17/15 at 7:00 PM to report the allegation of abuse involving Resident #1 which had occurred on 03/15/15. Continued interview, on 04/07/15 at 3:21 PM, revealed the staff who witnessed the incident on 03/15/15 were unsure of who to report the incident to since the abuse involved their Charge Nurse, RN #2. Per interview, therefore, RN #2 was allowed to continue to work and have access to all the residents.</p> <p>Interview, on 04/06/15 at 2:35 PM, with the Administrator revealed the incident involving Resident #1, on 03/15/15, was witnessed by three (3) staff members who had not reported alleged abuse immediately, and due to the failure of the three (3) staff to report the alleged abuse RN #2 was allowed to continue to work and have access to the facility's residents.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15, which alleged removal of the IJ effective</p>	F 223	
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F 223	<p>Continued From page 32 04/12/15. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> <li>1. On 03/18/15, the facility initiated an investigation into the incident involving Resident #1. The Social Worker (SW) interviewed Resident #1 regarding the alleged incident. The SW interviewed other residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater for possible abuse allegations committed by Registered Nurse (RN) #2.</li> <li>2. The Director of Nursing (DON) interviewed staff who had worked from 03/15/15, the date the alleged incident occurred through 03/17/15, regarding non-interviewable residents who might have had changes in their behaviors which might indicate possible abuse.</li> <li>3. The Administrator and DON reviewed the facility's abuse policy and determined the policy was in compliance with regulations.</li> <li>4. The DON counseled Certified Nursing Assistant (CNA) #1, CNA #7 and CNA #9, on 03/18/15, individually and educated each one (1) that all staff are to report abuse immediately and to call the Administrator, DON or SW if they could not report allegations to their immediate supervisor.</li> <li>5. After the investigation, it was determined the allegation was substantiated and Registered Nurse (RN) #2's employment was terminated on 03/18/15.</li> <li>6. On 04/06/15, the Administrator met with the SW to ensure she was fully aware of the facility's Abuse Prevention Policy.</li> </ol>	F 223			

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F 223	Continued From page 33  7. The SW educated all staff 04/08/15 through 04/11/15, on the facility's Abuse Prevention Policy, except for four (4) staff who were on medical leave. After the education was provided, staff had to take a post-test to determine they were knowledgeable and understood the abuse policy. The four (4) staff on medical leave will not be placed on the schedule for work until they have been educated.  8. On 04/08/15, the facility's new hire orientation was revised to include the abuse education and post-test, which new hires will receive prior to working to being oriented to their respective departments. This will go into effect for the next orientation date, 04/27/15.  9. On 04/09/15 through 04/11/15, the Administrator made rounds throughout the facility on all shifts to ensure staff were knowledgeable and had understanding of the facility's "Abuse Prevention Policy", which included questioning staff on the policy. Per the AOC, all staff replied appropriately to the questions asked by the Administrator.  10. On 04/10/15, Activities staff put up an abuse prevention bulletin board in the employee break room which included information on when to report abuse allegations, to whom they should report and the types of abuse.  11. All concerns regarding the "Abuse Prevention Policy" will be taken to the facility's Quality Assurance/Quality Improvement (QAPI) Committee, which consists of the Medical Director, Administrator, DON, ADON, SW, Maintenance Director, Activities Director,	F 223			

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F 223	<p>Continued From page 34</p> <p>Housekeeping/Laundry Supervisor and Dietary Manager which meets weekly.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the final "Resident Abuse Investigation Report Form", dated 03/20/15, and signed by the SW and Administrator, revealed the investigation into alleged verbal abuse of Resident #1 on 03/15/15, was initiated on 03/18/15, as per the AOC. Review of the Form revealed RN #2 was suspended on 03/18/15, other residents with a BIMS score of eight (8) or greater were interviewed for possible abuse allegations committed by RN #2.</p> <p>Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the investigation findings. The SW revealed she had interviewed residents with a BIMS score of eight (8) or greater for possible abuse allegations committed by RN #2, with no concerns voiced.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator confirmed the investigation was performed, the SW interviewed the interviewable residents and the allegation of verbal abuse by RN #2 had been substantiated.</p> <p>2. Interview, on 04/07/15 at 2:25 PM with Licensed Practical Nurse (LPN) #3, and on 04/15/15 with RN #4 at 11:45 AM, who had both worked from 03/15/15 through 03/17/15, revealed the DON had questioned them regarding residents who were non-interviewable, who might have had behavior changes which could have indicated possible abuse. Per interview, they had not observed any behavior changes in those</p>	F 223			

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F 223	<p>Continued From page 35 residents.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed she had questioned and interviewed staff who had worked during the 03/15/15 through 03/17/15 timeframe, about whether the staff had noticed changes in non-interviewable resident's behaviors, which might have indicated possible abuse. Per interview, no reports of behavior changes indicating possible abuse were verbalized by staff.</p> <p>3. Further review of the facility's final "Resident Abuse Investigation Report Form" revealed the facility's abuse policy was reviewed and it was determined no changes were needed.</p> <p>Interview, on 04/18/15 at 2:26 PM, with the DON and at 3:00 PM with the Administrator, revealed they had reviewed the facility's abuse policy and it was determined to be in compliance with the regulations.</p> <p>4. Review of the facility's final "Resident Abuse Investigation Report Form" revealed CNA #1, CNA #7 and CNA #9 were counseled by the DON during the facility's investigation, on immediately reporting allegations of abuse. Additionally, the DON educated the three (3) CNAs on calling the Administrator, DON or SW to report alleged abuse, if unable to report to their immediate supervisor.</p> <p>Interview, on 04/07/15 at 3:00 PM with CNA #9, at 4:20 PM with CNA #7 and at 4:30 PM with CNA #1, revealed they had all been educated on the facility's abuse policy and to report abuse immediately to their supervisor. Per interview, they were all educated if they couldn't report</p>	F 223			

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F 223	<p>Continued From page 36</p> <p>allegations of abuse to their supervisor, they should call the Administrator, DON or SW to report their allegations.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed she had counseled and educated CNA #1, CNA #7 and CNA #9 individually regarding the abuse policy and to report allegations of abuse immediately to their supervisor, and if they couldn't report to the supervisor they should call the Administrator, SW or her to report allegations of abuse.</p> <p>5. Review of the facility's final "Resident Abuse Investigation Report Form" revealed the allegation was substantiated and RN #2 was terminated on 03/18/15. Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the investigation findings.</p> <p>Review of RN #2's personnel file revealed the RN was terminated on 03/18/15.</p> <p>Interview, on 04/07/15 at 1:50 PM, with RN #2 revealed her employment at the facility had been terminated.</p> <p>Interview, on 04/16/15 at 3:00 PM with the Administrator, revealed RN #2's employment was terminated, as per the AOC.</p> <p>6. Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the Administrator had met with her and discussed her understanding of the facility's Abuse Prevention Policy.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator confirmed he had met with the SW and discussed her understanding of the facility's</p>	F 223			

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F 223	<p>Continued From page 37</p> <p>Abuse Prevention Policy to ensure she was fully aware of it.</p> <p>7. The facility's abuse inservice material and post-tests were reviewed and checked against the master list of current employees. Review of the facility's in-service sign-in forms for the dates of 04/08/15 through 04/11/15, revealed all staff disciplines were educated regarding the facility's abuse policy.</p> <p>Interviews on 04/15/15 with RN #4 at 11:45 AM; CNA #12 at 1:20 PM; House Keeping #14 at 1:25 PM; Dietary #15 at 1:30 PM; LPN #6 at 1:40 PM; LPN #1 at 1:50 PM; LPN #8 at 2:10 PM; CNA #13 at 2:20 PM; CNA #4 at 3:40 PM; CNA #11 at 3:50 PM; LPN #9 at 7:10 PM; RN #5 at 7:20 PM; CNA #3 at 10:05 PM; CNA #4 at 10:19 PM; CNA #17 at 10:25 PM; and CNA #18 at 10:30 PM; and on 04/16/15 with CNA #4 at 8:00 AM; CNA#3 at 8:20 PM; LPN #6 at 12:38 PM; CNA #5 at 1:58 PM; CNA #6 at 2:00 PM; CNA #11 at 3:55 PM; and LPN #7 at 4:05 PM, revealed they had all been educated on the facility's abuse policy and procedure and had taken a post-test.</p> <p>Interview, on 04/16/15 at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed the four (4) staff on medical leave would not be allowed to work until they had received the abuse education.</p> <p>8. The facility's new hire orientation information and education was reviewed and revealed it included the abuse education and post-test.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed the facility's new hire orientation included the abuse education and</p>	F 223	

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F 223	<p>Continued From page 38</p> <p>post-test and would go into effect 04/27/15, as per the AOC.</p> <p>9. The Administrator's and DON's daily rounds log sheet dated 04/06/15 through 04/11/15 were reviewed and revealed both documented rounds made on each day, on the three (3) different shifts regarding interviewing staff about if they were knowledgeable and had understanding of the policy.</p> <p>Interview, on 04/15/15 at 11:45 AM with RN #4; at 1:20 PM with CNA #12; at 1:25 PM with House Keeping #14; at 1:30 PM with Dietary #15; at 1:40 PM with LPN #6; at 1:50 PM with LPN #1; at 2:10 PM with LPN #8; at 2:20 PM with CNA #13; at 3:40 PM with CNA #4; at 3:50 PM with CNA #11; at 7:10 PM with LPN #9; at 7:20 PM with RN #5; at 10:05 PM with CNA #3; at 10:19 PM with CNA #4; at 10:25 PM with CNA #17; and at 10:30 PM with CNA #18 revealed the Administrator and DON had performed rounds and asked staff about the facility's abuse policy.</p> <p>Interview, on 04/16/15 at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed they had performed the rounds to interview staff about their knowledge and understanding of the abuse policy, as per the AOC.</p> <p>10. Observation, on 04/15/15 at 10:25 AM, of the employee break room revealed a bulletin board present which contained abuse information including when to report abuse allegations, who to report to and the types of abuse.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed Activity staff had put the bulletin board up in the employee break room.</p>	F 223			

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F 223	Continued From page 39 The Administrator revealed the board included abuse prevention information as per the AOC.  11. Interview, on 04/16/15 1:06 PM with the SW, at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed any concerns related to the facility's abuse policy would be taken to the facility's QAPI Committee, discussed and plans developed to implement.  Interview, on 04/16/15 at 1:20 PM, with the facility's Medical Director revealed he participated in the facility's QAPI Committee and had been informed of the incident involving Resident #1. The Medical Director stated any concerns regarding the facility's abuse policy would be discussed in the QAPI Committee meeting.	F 223			
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	DON counseled CNA #1, CNA #7, and CMA #9, on 3/18/15, individually and educated each that all staff is to report abuse immediately to supervisor. DON also educated each that if they could not report to supervisor that they should call Administrator, DON, or Social Worker and provided contact information as well. On 3/18/15 Social Worker, Administrator, and DON spoke with Resident #1 regarding allegation. Resident stated feeling safe at this time. On 3/20/15, Social Worker conducted a survey of residents with BIMS of 8 or higher. Resident #5 answered survey in		

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F 225	<p>Continued From page 40</p> <p>to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's abuse investigation and facility's policy, it was determined the facility failed to have an effective system to ensure all alleged incidents of abuse were reported immediately to Administration, residents were protected after an allegation of abuse, and Administration immediately reported the allegations to the appropriate State Agencies for two (2) of twelve (12) sampled residents (Residents #1 and Resident #5).</p> <p>On 03/15/15 around 7:30 PM, Registered Nurse (RN) #2 was overheard by staff to be yelling at Resident #1, and Resident #5 overheard RN #2 in the hallway stating, "I wish all you MF's would die". Although the incidents occurred on 03/15/15 around 7:30 PM, it was not reported by staff to</p>	F 225	<p>affirmative to question "Do you feel safe at facility?" On 4/8/15, Administrator conducted a review of Abuse Prevention policy with DON and Social Worker. Administrator educated DON and Social Worker that all alleged abuse allegations needed to be reported to appropriate State Agencies immediately per facility policy.</p> <p>On 3/20/15, Social Worker conducted a survey of residents with a Brief Interview for Mental Status (BIMS) score of eight and higher for possible abuse allegations of RN #2. No responses indicated further abuse allegations. DON interviewed staff working on dates 3/15/15 through 3/17/15 to identify behavioral changes of residents with BIMS scores less than eight that occurred during those date that might indicate abuse had occurred. No signs or symptoms reported as evidence of abuse.</p> <p>All staff, except for four, were educated on facility Abuse Prevention Policy by Social Worker. One LPN and three CNAs are currently on medical leave with unknown return dates; however, they will not be allowed to be placed on the schedule</p>		

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F 225	<p>Continued From page 41</p> <p>Administration until 03/17/15 at 7:00 PM, allowing RN #2 to work the entire shift on 03/15/15. An investigation report was not initiated until 03/18/15 and the alleged abuse was not reported to the appropriate State Agencies until 03/19/15 at 4:48 PM.</p> <p>Based on the above findings, it was determined the facility's failure to ensure all allegations of abuse were reported immediately to the facility's Administration, failure to ensure residents were protected after an allegation of abuse was reported, and failure to ensure Administration immediately reported the allegations to the appropriate State Agencies, was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 04/07/15 and was determined to exist on 03/15/15. The facility was notified of the Immediate Jeopardy on 04/07/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15 with the facility alleging removal of the Immediate Jeopardy on 04/12/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on 04/12/15, prior to exit on 04/16/15, with remaining non-compliance at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Abuse Prevention Plan", revised June 2013, revealed all allegations of abuse would be reported immediately to one (1) of the following: Charge</p>	F 225	<p>until they each have completed the required education with the Social Worker. The education was conducted on dates 4/8/15 through 4/16/15 by Social Worker. On 4/8/15, Administrator met with Social Worker to review Abuse Prevention Policy to ensure she was fully aware of policy, Social Worker educated staff as part of in service on procedures required when an abuse allegation involves an employee. Social Worker educated that the policy requires staff to walk employee to time clock and escort the employee out of facility, the resident should be placed on 1 on 1 care to ensure safety, and Social Worker, Administrator, or DON should then be contacted for further instructions. At the end of the education sessions all staff were also required to complete a post education test to determine knowledge and understanding of the policy. Employees were required to score ninety percent to pass. All staff that did not score ninety percent were reeducated and retested. The test included questions that asked when abuse should be reported, to whom, and types of abuse. New hire orientation has been revised to include post abuse education testing prior to new staff beginning orientation to</p>		

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F 225	Continued From page 42 Nurse, Director of Nursing (DON), Administrator, Administrator in Training or the Social Services Director (SSD). According to the Policy, any employee who failed to report allegations of abuse or neglect immediately could be held responsible for the same actions. The Policy revealed employees accused of abuse or neglect would not be permitted to work during the facility's investigation. Further review revealed allegations of abuse and/or neglect would be called in to the State Survey Agency, State Adult Protective Services and Long Term Care Ombudsman immediately upon notification of allegations.  Review of the facility's policy titled, "Resident Rights", revised August 2013, revealed the facility should ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, were reported immediately to the Administrator and to other officials in accordance with State law through established procedures. The Policy revealed the facility must prevent further abuse of residents while the investigation was in progress.  Review of the facility's, "Resident Abuse Investigation Report Form", which was signed by the SSD on 03/20/15, revealed an incident had been reported on 03/18/15, involving Resident #1 being verbally abused; however, the incident had occurred on 03/15/15. Continued review of the Form revealed even though the alleged abuse had been witnessed by three (3) staff members, the staff had failed to follow the facility's policy to immediately report abuse. Further review revealed the alleged abuse involving Resident #1 was not reported to the State Agencies until 03/19/15.	F 225	their respective departments. This revision is effective as of 4/8/15 with first staff orientation date on 4/27/15.  Administrator will review all abuse allegations to monitor for implementation of policy. Social Worker will conduct an audit of all staff regarding knowledge and understanding of Abuse Prevention policy weekly for 60 days, monthly for 120 days, bi-monthly for 120 days, and then quarterly thereafter. Social Worker will conduct audit by utilizing questionnaires covering types of abuse, signs and symptoms of abuse, reporting of abuse, and facility policies and procedures regarding abuse. Audits will be conducted on all shifts Monday through Sunday. Social Worker will immediately conduct retraining as needed for staff which does not display knowledge and understanding of Abuse Prevention policy. Social Worker will report all concerns and any need for retraining to the QAPI Committee. The Administrator will report all concerns regarding implementation of policy will be taken to QAPI Committee for further investigation and resolution.	6/12/15

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F 225	<p>Continued From page 43</p> <p>Interview with the SSD, on 04/07/15 at 3:08 PM and on 04/16/15 at 1:06 PM, revealed staff should have immediately reported the alleged abuse on 03/15/15, and the facility should have reported the incident to the State Agencies immediately.</p> <p>Continued review of the facility's, "Resident Abuse Investigation Report Form", revealed Certified Nursing Assistant (CNA) #1, CNA #7 and Certified Medication Aide (CMA) #9 witnessed RN #2 yelling at Resident #1 on 03/15/15 around 7:30 PM.</p> <p>Interview with Resident #1, on 04/07/15 at 2:40 PM, revealed a nurse did "yell" at him/her for coughing in her face.</p> <p>Interview with CNA #1, on 04/07/15 at 4:30 PM, revealed on she heard RN #2 stating she "hated" Resident #1 and all the other residents on 03/15/15 around 7:30 PM. CNA #1 revealed she had considered what she witnessed as verbal abuse, but didn't immediately report it because RN #2 was the Charge Nurse, her supervisor. Further interview revealed RN #2 continued caring for residents the remainder of the shift, approximately ten (10) hours, after the incident occurred.</p> <p>Interview with CNA #7, on 04/07/15 at 4:20 PM, revealed she had been standing in the hallway on 03/15/15 around 7:30 PM, when she overheard RN #2 yelling at Resident #1 to stop coughing in her face. CNA #7 revealed when the RN came out of Resident #1's room, she (RN #1) stated she was not a "people person" and hated all the residents. Per interview, CNA #7 considered what RN #1 had done as verbal abuse, but did</p>	F 225			

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F 225	<p>Continued From page 44</p> <p>not immediately report the abuse, as the RN was the Charge Nurse and she did not know who to report to if the Charge Nurse had committed the abuse. According to CNA #7, RN #2 continued to remain caring for resident for the remainder of the shift which was approximately ten (10) hours, after the incident.</p> <p>Interview, on 04/02/15 at 1:00 PM, with Resident #5, who resided near Resident #1, revealed on 03/15/15, he/she overheard RN #2 saying, "I wish all you MF's would die" and this comment upset the resident.</p> <p>Interview with CMA #9 on 04/07/15 at 2:30 PM, revealed she had witnessed RN #2 yelling at Resident #1 on 03/15/15, to stop coughing in her face. Per interview, CMA #9 thought what she had witnessed was abuse, but the CNA's (CNA #1 and #7) had witnessed the whole incident and she thought they were going to report the abuse. CMA #9 stated the abuse should have been reported to the nurse on the other hall immediately.</p> <p>Interview with the Director of Nursing (DON), on 04/02/15 at 11:40 AM and on 04/07/15 at 3:21 PM, revealed CNA #1 had called her at home on her cellular telephone (cell phone) on 03/17/15 at 7:00 PM, reporting an allegation of abuse which had occurred on 03/15/15. Per the DON, after CNA #1's phone call, she had called the SSD and Administrator to notify them of the CNA's allegation of abuse. The DON revealed the staff who were present on 03/15/15 and witnessed the incident were not sure who they were to report the abuse to, since the abuse involved their Charge Nurse. She reported RN #2 continued to work caring for residents; however, the staff</p>	F 225			

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F 225	<p>Continued From page 45</p> <p>should have reported the allegation of abuse immediately. According to the DON, as a result of staff not reporting the alleged abuse, the facility had failed to ensure the safety and protection of the residents from further abuse. Continued interview revealed she had not identified during the facility's investigation that there might be a facility wide issue regarding staff's abuse education and the importance of immediately reporting all allegations of abuse. Per interview, she had not identified there might be other staff unsure of the facility's reporting procedures for alleged abuse. The DON revealed the facility should have reported the incident involving Resident #1, when she was notified of the alleged abuse on 03/17/15. Further interview revealed, the facility should report all allegations of abuse to the State Agencies immediately upon notification.</p> <p>Interview with the Administrator, on 04/06/15 at 2:35 PM and 04/07/15 at 3:30 PM, revealed the three (3) staff who had witnessed the incident involving Resident #1 and #5, on 03/15/15, did not report the incident immediately. The Administrator revealed the staff's failure to report the alleged abuse allowed RN #2 to continue to work caring for residents. Therefore, the Administrator stated the facility had unable to ensure residents' safety from further abuse. Continued interview revealed the facility's policy and procedure for abuse was for staff to report all allegations of abuse to their Charge Nurse, the SSD, the DON or him immediately to ensure residents' safety was maintained.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15, which alleged removal of the IJ effective 04/12/15. Review of the AOC revealed the facility</p>	F 225			

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F 225	Continued From page 46 Implemented the following:  1. On 03/18/15, the facility initiated an investigation into the incident involving Resident #1. The Social Worker (SW) interviewed Resident #1 regarding the alleged incident. The SW interviewed other residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater for possible abuse allegations committed by Registered Nurse (RN) #2.  2. The Director of Nursing (DON) interviewed staff who had worked from 03/15/15, the date the alleged incident occurred through 03/17/15, regarding non-interviewable residents who might have had changes in their behaviors which might indicate possible abuse.  3. The Administrator and DON reviewed the facility's abuse policy and determined the policy was in compliance with regulations.  4. The DON counseled Certified Nursing Assistant (CNA) #1, CNA #7 and CNA #9, on 03/18/15, individually and educated each one (1) that all staff are to report abuse immediately and to call the Administrator, DON or SW if they could not report allegations to their immediate supervisor.  5. After the investigation, it was determined the allegation was substantiated and Registered Nurse (RN) #2's employment was terminated on 03/18/15.  6. On 04/06/15, the Administrator met with the SW to ensure she was fully aware of the facility's Abuse Prevention Policy.	F 225		

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F 225	<p>Continued From page 47</p> <p>7. The SW educated all staff 04/08/15 through 04/11/15, on the facility's Abuse Prevention Policy, except for four (4) staff who were on medical leave. After the education was provided, staff had to take a post-test to determine they were knowledgeable and understood the abuse policy. The four (4) staff on medical leave will not be placed on the schedule for work until they have been educated.</p> <p>8. On 04/08/15, the facility's new hire orientation was revised to include the abuse education and post-test, which new hires will receive prior to working to being oriented to their respective departments. This will go into effect for the next orientation date, 04/27/15.</p> <p>9. On 04/09/15 through 04/11/15, the Administrator made rounds throughout the facility on all shifts to ensure staff were knowledgeable and had understanding of the facility's "Abuse Prevention Policy", which included questioning staff on the policy. Per the AOC, all staff replied appropriately to the questions asked by the Administrator.</p> <p>10. On 04/10/15, Activities staff put up an abuse prevention bulletin board in the employee break room which included information on when to report abuse allegations, to whom they should report and the types of abuse.</p> <p>11. All concerns regarding the "Abuse Prevention Policy" will be taken to the facility's Quality Assurance/Quality Improvement (QAPI) Committee, which consists of the Medical Director, Administrator, DON, ADON, SW, Maintenance Director, Activities Director, Housekeeping/Laundry Supervisor and Dietary</p>	F 225			

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F 225	<p>Continued From page 48 Manager which meets weekly.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the final "Resident Abuse Investigation Report Form", dated 03/20/15, and signed by the SW and Administrator, revealed the investigation into alleged verbal abuse of Resident #1 on 03/15/15, was initiated on 03/18/15, as per the AOC. Review of the Form revealed RN #2 was suspended on 03/18/15, other residents with a BIMS score of eight (8) or greater were interviewed for possible abuse allegations committed by RN #2.</p> <p>Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the investigation findings. The SW revealed she had interviewed residents with a BIMS score of eight (8) or greater for possible abuse allegations committed by RN #2, with no concerns voiced.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator confirmed the investigation was performed, the SW interviewed the interviewable residents and the allegation of verbal abuse by RN #2 had been substantiated.</p> <p>2. Interview, on 04/07/15 at 2:25 PM with Licensed Practical Nurse (LPN) #3, and on 04/15/15 with RN #4 at 11:45 AM, who had both worked from 03/15/15 through 03/17/15, revealed the DON had questioned them regarding residents who were non-interviewable, who might have had behavior changes which could have indicated possible abuse. Per Interview, they had not observed any behavior changes in those residents.</p>	F 225			

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F 225	<p>Continued From page 49</p> <p>Interview, on 04/16/15 at 2:28 PM, with the DON revealed she had questioned and interviewed staff who had worked during the 03/15/15 through 03/17/15 timeframe, about whether the staff had noticed changes in non-interviewable resident's behaviors, which might have indicated possible abuse. Per interview, no reports of behavior changes indicating possible abuse were verbalized by staff.</p> <p>3. Further review of the facility's final "Resident Abuse Investigation Report Form" revealed the facility's abuse policy was reviewed and it was determined no changes were needed.</p> <p>Interview, on 04/16/15 at 2:28 PM, with the DON and at 3:00 PM with the Administrator, revealed they had reviewed the facility's abuse policy and it was determined to be in compliance with the regulations.</p> <p>4. Review of the facility's final "Resident Abuse Investigation Report Form" revealed CNA #1, CNA #7 and CNA #9 were counseled by the DON during the facility's investigation, on immediately reporting allegations of abuse. Additionally, the DON educated the three (3) CNAs on calling the Administrator, DON or SW to report alleged abuse, if unable to report to their immediate supervisor.</p> <p>Interview, on 04/07/15 at 3:00 PM with CNA #9, at 4:20 PM with CNA #7 and at 4:30 PM with CNA #1, revealed they had all been educated on the facility's abuse policy and to report abuse immediately to their supervisor. Per interview, they were all educated if they couldn't report allegations of abuse to their supervisor, they</p>	F 225			

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F 225	<p>Continued From page 50 should call the Administrator, DON or SW to report their allegations.</p> <p>Interview, on 04/16/15 at 2:28 PM, with the DON revealed she had counseled and educated CNA #1, CNA #7 and CNA #9 Individually regarding the abuse policy and to report allegations of abuse immediately to their supervisor, and if they couldn't report to the supervisor they should call the Administrator, SW or her to report allegations of abuse.</p> <p>5. Review of the facility's final "Resident Abuse Investigation Report Form" revealed the allegation was substantiated and RN #2 was terminated on 03/18/15. Interview, on 04/16/15 at 1:08 PM, with the SW confirmed the investigation findings.</p> <p>Review of RN #2's personnel file revealed the RN was terminated on 03/18/15.</p> <p>Interview, on 04/07/15 at 1:50 PM, with RN #2 revealed her employment at the facility had been terminated.</p> <p>Interview, on 04/18/15 at 3:00 PM with the Administrator, revealed RN #2's employment was terminated, as per the AOC.</p> <p>6. Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the Administrator had met with her and discussed her understanding of the facility's Abuse Prevention Policy.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator confirmed he had met with the SW and discussed her understanding of the facility's Abuse Prevention Policy to ensure she was fully</p>	F 225			

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F 225	<p>Continued From page 51 aware of it.</p> <p>7. The facility's abuse inservice material and post-tests were reviewed and checked against the master list of current employees. Review of the facility's in-service sign-in forms for the dates of 04/08/15 through 04/11/15, revealed all staff disciplines were educated regarding the facility's abuse policy.</p> <p>Interviews on 04/15/15 with RN #4 at 11:45 AM; CNA #12 at 1:20 PM; House Keeping #14 at 1:25 PM; Dietary #15 at 1:30 PM; LPN #6 at 1:40 PM; LPN #1 at 1:50 PM; LPN #8 at 2:10 PM; CNA #13 at 2:20 PM; CNA #4 at 3:40 PM; CNA #11 at 3:50 PM; LPN #9 at 7:10 PM; RN #5 at 7:20 PM; CNA #3 at 10:05 PM; CNA #4 at 10:19 PM; CNA #17 at 10:25 PM; and CNA #18 at 10:30 PM; and on 04/16/15 with CNA #4 at 8:00 AM; CNA#3 at 8:20 PM; LPN #6 at 12:38 PM; CNA #5 at 1:58 PM; CNA #6 at 2:00 PM; CNA #11 at 3:55 PM; and LPN #7 at 4:05 PM, revealed they had all been educated on the facility's abuse policy and procedure and had taken a post-test.</p> <p>Interview, on 04/16/15 at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed the four (4) staff on medical leave would not be allowed to work until they had received the abuse education.</p> <p>8. The facility's new hire orientation information and education was reviewed and revealed it included the abuse education and post-test.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed the facility's new hire orientation included the abuse education and post-test and would go into effect 04/27/15, as</p>	F 225			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/16/2015
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
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F 225	Continued From page 52 per the AOC.  9. The Administrator's and DON's daily rounds log sheet dated 04/06/15 through 04/11/15 were reviewed and revealed both documented rounds made on each day, on the three (3) different shifts regarding interviewing staff about if they were knowledgeable and had understanding of the policy.  Interview, on 04/15/15 at 11:45 AM with RN #4; at 1:20 PM with CNA #12; at 1:25 PM with House Keeping #14; at 1:30 PM with Dietary #15; at 1:40 PM with LPN #6; at 1:50 PM with LPN #1; at 2:10 PM with LPN #8; at 2:20 PM with CNA #13; at 3:40 PM with CNA #4; at 3:50 PM with CNA #11; at 7:10 PM with LPN #9; at 7:20 PM with RN #5; at 10:05 PM with CNA #3; at 10:19 PM with CNA #4; at 10:25 PM with CNA #17; and at 10:30 PM with CNA #18 revealed the Administrator and DON had performed rounds and asked staff about the facility's abuse policy.  Interview, on 04/16/15 at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed they had performed the rounds to interview staff about their knowledge and understanding of the abuse policy, as per the AOC.  10. Observation, on 04/15/15 at 10:25 AM, of the employee break room revealed a bulletin board present which contained abuse information including when to report abuse allegations, who to report to and the types of abuse.  Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed Activity staff had put the bulletin board up in the employee break room. The Administrator revealed the board included	F 225			

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F 225	Continued From page 53 abuse prevention information as per the AOC.  11. Interview, on 04/16/15 1:06 PM with the SW, at 2:28 PM with the DON and at 3:00 PM, with the Administrator revealed any concerns related to the facility's abuse policy would be taken to the facility's QAPI Committee, discussed and plans developed to implement.  Interview, on 04/16/15 at 1:20 PM, with the facility's Medical Director revealed he participated in the facility's QAPI Committee and had been informed of the incident involving Resident #1. The Medical Director stated any concerns regarding the facility's abuse policy would be discussed in the QAPI Committee meeting.	F 225			
F 226 SS=J	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation and the facility's policies, it was determined the facility failed to have an effective system to ensure its abuse policy and procedures were implemented for two (2) of twelve (12) sampled residents (Resident #1 and #5). On 03/15/15 around 7:30 PM, three (3) staff overheard RN #2 yelling at Resident #1 to quit coughing in her face. Interviews with witnesses, revealed RN #2 was also overheard making	F 226	DON counseled CNA #1, CNA #7, and CMA #9, on 3/18/15, individually and educated each that all staff is to report abuse immediately to supervisor. DON also educated each that if they could not report to supervisor that they should call Administrator, DON, or Social Worker and provided contact information as well. On 3/18/15 Social Worker, Administrator, and DON spoke with Resident #1 regarding allegation. Resident stated feeling safe at this time. On 3/20/15, Social Worker conducted a survey of residents with BIMS of 8 or higher. Resident #5 answered survey in affirmative to question "Do you feel safe at facility?" On 4/8/15,		

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F 226	<p>Continued From page 54</p> <p>statements in the hallway that she (RN #2) hated Resident #1 and all the facility's residents. Interview with Resident #5, who resided near Resident #1, overheard RN #2 state, "I wish all you MF's would die". (Refer to F223 and F225)</p> <p>Based on the above findings, it was determined the facility's failure to implement its abuse policy and procedures was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 04/07/15 and was determined to exist on 03/15/15. The facility was notified of the Immediate Jeopardy on 04/07/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/14 with the facility alleging removal of the Immediate Jeopardy on 04/12/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on 04/12/15, prior to exit on 04/16/15, with remaining non-compliance at 42 CFR 483.13, Resident Behavior and Facility Practice, F-226 Abuse, at a Scope and Severity of an "D", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure abuse policy and procedures are implemented.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Rights", revised August 2013, revealed the facility should ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, were reported immediately to the Administrator and to other officials in accordance with State Law through its</p>	F 226	<p>Administrator conducted a review of Abuse Prevention policy with DON and Social Worker. Administrator educated DON and Social Worker that all alleged abuse allegations needed to be reported to appropriate State Agencies immediately per facility policy.</p> <p>On 3/20/15, Social Worker conducted a survey of residents with a Brief Interview for Mental Status (BIMS) score of eight and higher for possible abuse allegations of RN #2. No responses indicated further abuse allegations. DON interviewed staff working on dates 3/15/15 through 3/17/15 to identify behavioral changes of residents with BIMS scores less than eight that occurred during those date that might indicate abuse had occurred. No signs or symptoms reported as evidence of abuse.</p> <p>All staff, except for four, were educated on facility Abuse Prevention Policy by Social Worker. One LPN and three CNAs are currently on medical leave with unknown return dates; however, they will not be allowed to be placed on the schedule until they each have completed the required education with the Social</p>		

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F 226	<p>Continued From page 55</p> <p>established procedures. Further review revealed the facility must have evidence all alleged violations were thoroughly investigated, and must prevent further abuse from occurring while its investigation was in progress.</p> <p>Review of the facility's policy, titled "Abuse Prevention Plan", revised June 2013, revealed staff were to report all allegations of abuse immediately to either the Charge Nurse, Director of Nursing (DON), Administrator, Administrator in Training or Social Services Director (SSD). Continued review revealed allegations of abuse and/or neglect would be called in to the State Survey Agency, State Adult Protective Services, the local Long Term Care Ombudsman, the resident's Physician, and the resident's family/responsible party immediately upon notification of the allegation. Further review revealed failure by any employee to report abuse or neglect immediately meant the employee could be held responsible for the same actions. In addition, the Policy revealed employees accused of any type of abuse or neglect would not be permitted to work during the facility's investigation.</p> <p>Interview with the DON on 04/07/15 at 3:21 PM, revealed she was notified by CNA #1 of an allegation of verbal abuse on the evening of 03/17/15. However, review of the facility's, "Resident Abuse Investigation Report Form", which was signed by the SSD on 03/20/15, revealed an incident had been reported on 03/18/15, involving Resident #1 being verbally abused; however, the incident had occurred on 03/15/15. Continued review of the "Resident Abuse Investigation Report Form" revealed the incident had been witnessed by CNA #1, CNA #7</p>	F 226	<p>Worker. The education was conducted on dates 4/8/15 through 4/16/15 by Social Worker. On 4/8/15, Administrator met with Social Worker to review Abuse Prevention Policy to ensure she was fully aware of policy. Social Worker educated staff as part of in service on procedures required when an abuse allegation involves an employee. Social Worker educated that the policy requires staff to walk employee to time clock and escort the employee out of facility, the resident should be placed on 1 on 1 care to ensure safety, and Social Worker, Administrator, or DON should then be contacted for further instructions. At the end of the education sessions all staff were also required to complete a post education test to determine knowledge and understanding of the policy. Employees were required to score ninety percent to pass. All staff that did not score ninety percent were reeducated and retested. The test included questions that asked when abuse should be reported, to whom, and types of abuse. New hire orientation has been revised to include post abuse education testing prior to new staff beginning orientation to their respective departments. This</p>		

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F 226	Continued From page 56 and Certified Medication Aide (CMA) #9. Further review of the Form revealed the facility did not report the allegation of abuse to the State Agencies until 03/19/15.  Interview, on 04/07/15 at 4:30 PM, with CNA #1, revealed on 03/15/15 around 7:30 PM, she heard RN #2 yelling at Resident #1, and heard the RN state she (RN #2) hated Resident #1 and all of the facility's residents. Per interview, CNA #1 considered what she had witnessed as verbal abuse; however, she did not immediately report the abuse, as per the facility's policy. According to CNA #1, she was a new employee and in orientation she had been educated to report alleged abuse to the Charge Nurse. She stated RN #2 was the Charge Nurse the night the incident occurred, so she didn't know who to report the abuse to.  Interview, on 04/07/15 at 4:20 PM, with CNA #7, revealed on 03/15/15 around 7:30 PM, she was standing in the hallway when she overheard RN #2 yelling at Resident #1. Per interview, RN #2 later stated while standing in the hallway she hated all the facility's residents. According to CNA #7, she considered what she had witnessed as verbal abuse; however, she did not immediately report the abuse, as per the facility's policy. Continued interview revealed since RN #2 had been the Charge Nurse that night, she didn't know who to report the abuse to, since her orientation education on abuse had been for the CNAs to report alleged abuse to the Charge Nurse.  Interview, on 04/07/15 at 2:30 PM, with CMA #9 revealed on 03/15/15, she had overheard RN #2 yelling at Resident #1 to stop coughing in her	F 226	revision is effective as of 4/8/15 with first staff orientation date on 4/27/15.  Administrator will review all abuse allegations to monitor for implementation of policy. Social Worker will conduct an audit of all staff regarding knowledge and understanding of Abuse Prevention policy weekly for 60 days, monthly for 120 days, bi-monthly for 120 days, and then quarterly thereafter. Social Worker will conduct audit by utilizing questionnaires covering types of abuse, signs and symptoms of abuse, reporting of abuse, and facility policies and procedures regarding abuse. Audits will be conducted on all shifts Monday through Sunday. Social Worker will immediately conduct retraining as needed for staff which does not display knowledge and understanding of Abuse Prevention policy. Social Worker will report all concerns and any need for retraining to the QAPI Committee. The Administrator will report all concerns regarding implementation of policy will be taken to QAPI Committee for further investigation and resolution.	6/12/15	

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F 226	<p>Continued From page 57</p> <p>face. Per interview, she felt what she had heard was verbal abuse, but didn't report it herself because the CNAs had witnessed the whole incident and she thought they going to report it. According to CMA #9, the verbal abuse should have been reported to the nurse working on the other hall.</p> <p>Interview, on 04/07/15 at 3:08 PM and on 04/16/15 at 1:06 PM, with the SSD revealed the staff who witnessed the incident on 03/15/15, should have immediately reported the alleged abuse; however, had not followed the facility's abuse reporting process and policy on 03/15/15 when they failed to immediately report it. According to the SSD, if staff witnessed alleged abuse, they should immediately report the allegations to her, the DON, Administrator or their supervisor, as per the policy. Continued interview revealed the facility's policy was for all allegations of abuse to be reported to the State Agencies immediately upon the facility receiving notification of an alleged abuse incident. Per interview, the DON was notified on 03/17/15, at night, and she (SSD) was not aware of this information, as the DON did not report the alleged abuse to her until 03/18/15. Therefore, she revealed she did not notify the State Survey Agency until 03/19/15; however, it should have been reported to the State Survey Agency on 03/18/15.</p> <p>Interview, on 04/02/15 at 11:40 AM and at 2:19 PM, and on 04/07/15 at 9:35 AM and at 3:21 PM, with the DON revealed because RN #2 was the Charge Nurse on 03/15/15, the staff who witnessed the incident had been unsure of who to report the incident as the abuse involved the Charge Nurse. Per interview, the facility's policy was not followed by staff on 03/15/15, and there</p>	F 226			

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F 226	Continued From page 58  was a delay in staff reporting the incident to the facility's Administration. The DON revealed the facility's policy was to immediately report all allegations of abuse within twenty-four (24) hours to the State Agencies upon notification of the incident. She stated however, the facility's policy had not been followed for the incident of 03/15/15, since the incident was not reported until 03/17/15, when CNA #1 called her at home to report it. Further interview revealed she had notified the SSD and Administrator on 03/17/15, of the incident after it was reported to her by CNA #1. However, in interview the SSD stated the DON did not report the alleged abuse to her until 03/18/15. Further interview with the DON revealed the facility did not follow the policy to report incidents immediately.  Interview with the Administrator, on 04/06/15 at 2:35 PM and on 04/07/15 at 4:00 PM, revealed the facility's policy and procedure for abuse was staff were to report all allegations of abuse immediately to either the Charge Nurse, the SSD, the DON or him to ensure residents' safety. Per interview, the incident involving Resident #1 which occurred on 03/15/15, was witnessed by three (3) staff members who failed to report the incident immediately, as per the facility's policy. The Administrator revealed the facility's policy was also to immediately report all allegations of abuse to the State Agencies after being notified of an alleged abuse incident. However, per interview, the facility had not followed the policy to report immediately.  The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15, which alleged removal of the IJ effective 04/12/15. Review of the AOC revealed the facility	F 226			

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F 226	<p>Continued From page 59 implemented the following:</p> <ol style="list-style-type: none"> <li>1. On 03/18/15, the facility initiated an investigation into the incident involving Resident #1. The Social Worker (SW) interviewed Resident #1 regarding the alleged incident. The SW interviewed other residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater for possible abuse allegations committed by Registered Nurse (RN) #2.</li> <li>2. The Director of Nursing (DON) interviewed staff who had worked from 03/15/15, the date the alleged incident occurred through 03/17/15, regarding non-interviewable residents who might have had changes in their behaviors which might indicate possible abuse.</li> <li>3. The Administrator and DON reviewed the facility's abuse policy and determined the policy was in compliance with regulations.</li> <li>4. The DON counseled Certified Nursing Assistant (CNA) #1, CNA #7 and CNA #9, on 03/18/15, individually and educated each one (1) that all staff are to report abuse immediately and to call the Administrator, DON or SW if they could not report allegations to their immediate supervisor.</li> <li>5. After the investigation, it was determined the allegation was substantiated and Registered Nurse (RN) #2's employment was terminated on 03/18/15.</li> <li>6. On 04/08/15, the Administrator met with the SW to ensure she was fully aware of the facility's Abuse Prevention Policy.</li> </ol>	F 226			

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F 226	Continued From page 60 7. The SW educated all staff 04/08/15 through 04/11/15, on the facility's Abuse Prevention Policy, except for four (4) staff who were on medical leave. After the education was provided, staff had to take a post-test to determine they were knowledgeable and understood the abuse policy. The four (4) staff on medical leave will not be placed on the schedule for work until they have been educated.  8. On 04/08/15, the facility's new hire orientation was revised to include the abuse education and post-test, which new hires will receive prior to working to being oriented to their respective departments. This will go into effect for the next orientation date, 04/27/15.  9. On 04/09/15 through 04/11/15, the Administrator made rounds throughout the facility on all shifts to ensure staff were knowledgeable and had understanding of the facility's "Abuse Prevention Policy", which included questioning staff on the policy. Per the AOC, all staff replied appropriately to the questions asked by the Administrator.  10. On 04/10/15, Activities staff put up an abuse prevention bulletin board in the employee break room which included information on when to report abuse allegations, to whom they should report and the types of abuse.  11. All concerns regarding the "Abuse Prevention Policy" will be taken to the facility's Quality Assurance/Quality Improvement (QAPI) Committee, which consists of the Medical Director, Administrator, DON, ADON, SW, Maintenance Director, Activities Director, Housekeeping/Laundry Supervisor and Dietary	F 226			

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F 226	<p>Continued From page 61 Manager which meets weekly.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the final "Resident Abuse Investigation Report Form", dated 03/20/15, and signed by the SW and Administrator, revealed the investigation into alleged verbal abuse of Resident #1 on 03/15/15, was initiated on 03/18/15, as per the AOC. Review of the Form revealed RN #2 was suspended on 03/18/15, other residents with a BIMS score of eight (8) or greater were interviewed for possible abuse allegations committed by RN #2.</p> <p>Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the investigation findings. The SW revealed she had interviewed residents with a BIMS score of eight (8) or greater for possible abuse allegations committed by RN #2, with no concerns voiced.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator confirmed the investigation was performed, the SW interviewed the interviewable residents and the allegation of verbal abuse by RN #2 had been substantiated.</p> <p>2. Interview, on 04/07/15 at 2:25 PM with Licensed Practical Nurse (LPN) #3, and on 04/15/15 with RN #4 at 11:45 AM, who had both worked from 03/15/15 through 03/17/15, revealed the DON had questioned them regarding residents who were non-interviewable, who might have had behavior changes which could have indicated possible abuse. Per Interview, they had not observed any behavior changes in those residents.</p>	F 226		

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F 226	Continued From page 62  Interview, on 04/16/15 at 2:26 PM, with the DON revealed she had questioned and interviewed staff who had worked during the 03/15/15 through 03/17/15 timeframe, about whether the staff had noticed changes in non-interviewable resident's behaviors, which might have indicated possible abuse. Per interview, no reports of behavior changes indicating possible abuse were verbalized by staff.  3. Further review of the facility's final "Resident Abuse Investigation Report Form" revealed the facility's abuse policy was reviewed and it was determined no changes were needed.  Interview, on 04/16/15 at 2:26 PM, with the DON and at 3:00 PM with the Administrator, revealed they had reviewed the facility's abuse policy and it was determined to be in compliance with the regulations.  4. Review of the facility's final "Resident Abuse Investigation Report Form" revealed CNA #1, CNA #7 and CNA #9 were counseled by the DON during the facility's investigation, on immediately reporting allegations of abuse. Additionally, the DON educated the three (3) CNAs on calling the Administrator, DON or SW to report alleged abuse, if unable to report to their immediate supervisor.  Interview, on 04/07/15 at 3:00 PM with CNA #9, at 4:20 PM with CNA #7 and at 4:30 PM with CNA #1, revealed they had all been educated on the facility's abuse policy and to report abuse immediately to their supervisor. Per interview, they were all educated if they couldn't report allegations of abuse to their supervisor, they	F 226			

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F 226	<p>Continued From page 63</p> <p>should call the Administrator, DON or SW to report their allegations.</p> <p>Interview, on 04/16/15 at 2:26 PM, with the DON revealed she had counseled and educated CNA #1, CNA #7 and CNA #9 individually regarding the abuse policy and to report allegations of abuse immediately to their supervisor, and if they couldn't report to the supervisor they should call the Administrator, SW or her to report allegations of abuse.</p> <p>5. Review of the facility's final "Resident Abuse Investigation Report Form" revealed the allegation was substantiated and RN #2 was terminated on 03/18/15. Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the investigation findings.</p> <p>Review of RN #2's personnel file revealed the RN was terminated on 03/18/15.</p> <p>Interview, on 04/07/15 at 1:50 PM, with RN #2 revealed her employment at the facility had been terminated.</p> <p>Interview, on 04/16/15 at 3:00 PM with the Administrator, revealed RN #2's employment was terminated, as per the AOC.</p> <p>6. Interview, on 04/16/15 at 1:06 PM, with the SW confirmed the Administrator had met with her and discussed her understanding of the facility's Abuse Prevention Policy.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator confirmed he had met with the SW and discussed her understanding of the facility's Abuse Prevention Policy to ensure she was fully</p>	F 226			

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F 226	<p>Continued From page 64 aware of it.</p> <p>7. The facility's abuse inservice material and post-tests were reviewed and checked against the master list of current employees. Review of the facility's in-service sign-in forms for the dates of 04/08/15 through 04/11/15, revealed all staff disciplines were educated regarding the facility's abuse policy.</p> <p>Interviews on 04/15/15 with RN #4 at 11:45 AM; CNA #12 at 1:20 PM; House Keeping #14 at 1:25 PM; Dietary #15 at 1:30 PM; LPN #6 at 1:40 PM; LPN #1 at 1:50 PM; LPN #8 at 2:10 PM; CNA #13 at 2:20 PM; CNA #4 at 3:40 PM; CNA #11 at 3:50 PM; LPN #9 at 7:10 PM; RN #5 at 7:20 PM; CNA #3 at 10:05 PM; CNA #4 at 10:19 PM; CNA #17 at 10:25 PM; and CNA #18 at 10:30 PM; and on 04/16/15 with CNA #4 at 8:00 AM; CNA#3 at 8:20 PM; LPN #6 at 12:38 PM; CNA #5 at 1:58 PM; CNA #6 at 2:00 PM; CNA #11 at 3:55 PM; and LPN #7 at 4:05 PM, revealed they had all been educated on the facility's abuse policy and procedure and had taken a post-test.</p> <p>Interview, on 04/16/15 at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed the four (4) staff on medical leave would not be allowed to work until they had received the abuse education.</p> <p>8. The facility's new hire orientation information and education was reviewed and revealed it included the abuse education and post-test.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed the facility's new hire orientation included the abuse education and post-test and would go into effect 04/27/15, as</p>	F 226			

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F 226	<p>Continued From page 65 per the AOC.</p> <p>9. The Administrator's and DON's daily rounds log sheet dated 04/06/15 through 04/11/15 were reviewed and revealed both documented rounds made on each day, on the three (3) different shifts regarding interviewing staff about if they were knowledgeable and had understanding of the policy.</p> <p>Interview, on 04/15/15 at 11:45 AM with RN #4; at 1:20 PM with CNA #12; at 1:25 PM with House Keeping #14; at 1:30 PM with Dietary #15; at 1:40 PM with LPN #6; at 1:50 PM with LPN #1; at 2:10 PM with LPN #8; at 2:20 PM with CNA #13; at 3:40 PM with CNA #4; at 3:50 PM with CNA #11; at 7:10 PM with LPN #9; at 7:20 PM with RN #5; at 10:05 PM with CNA #3; at 10:19 PM with CNA #4; at 10:25 PM with CNA #17; and at 10:30 PM with CNA #18 revealed the Administrator and DON had performed rounds and asked staff about the facility's abuse policy.</p> <p>Interview, on 04/18/15 at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed they had performed the rounds to interview staff about their knowledge and understanding of the abuse policy, as per the AOC.</p> <p>10. Observation, on 04/15/15 at 10:25 AM, of the employee break room revealed a bulletin board present which contained abuse information including when to report abuse allegations, who to report to and the types of abuse.</p> <p>Interview, on 04/16/15 at 3:00 PM, with the Administrator revealed Activity staff had put the bulletin board up in the employee break room. The Administrator revealed the board included</p>	F 226			

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F 226	Continued From page 66 abuse prevention information as per the AOC.  11. Interview, on 04/16/15 1:06 PM with the SW, at 2:26 PM with the DON and at 3:00 PM, with the Administrator revealed any concerns related to the facility's abuse policy would be taken to the facility's QAPI Committee, discussed and plans developed to implement.  Interview, on 04/16/15 at 1:20 PM, with the facility's Medical Director revealed he participated in the facility's QAPI Committee and had been informed of the incident involving Resident #1. The Medical Director stated any concerns regarding the facility's abuse policy would be discussed in the QAPI Committee meeting.	F 226			
F 279 SS=K	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	On 4/7/15, MDS staff completed an update of Comprehensive Care Plans (CCP) for residents #1, #3, #4, #5, #6, #7, #8, #9, #10, and #11 to reflect each resident's advance directives. Residents #2 and #12 CCP was not updated as they had been discharged from facility.  On 4/7/15, upon review of all resident CCPs, MDS staff determined that resident advance directives were not documented in CCPs. MDS staff updated all resident CCP to reflect residents' advance directives on 4/7/15. MDS staff conferred with Medical Records staff to verify all residents' code status was correct.  MDS staff updated all resident care		

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F 279	Continued From page 67 under §483.10(b)(4).  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 the Comprehensive Care Plan was developed related to residents' Advance Directives and code status for twelve (12) of twelve (12) sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12) to ensure the resident's code status was honored and Cardiopulmonary Resuscitation (CPR) was provided as requested when Resident #2 was found unresponsive on 03/28/15.  Resident #2's Responsible Party signed a document on 03/25/15, requesting to have CPR provided in the event of cardiac or respiratory failure. However, review of Resident #2's Comprehensive Care Plan revealed no documented evidence of a care plan developed regarding the resident's requested Full Code Status (a Full Code status indicates in the event of cardiac or respiratory failure, life-saving measures would be initiated) with interventions to address his/her code status.  At approximately 4:50 AM on 03/28/15, Registered Nurse (RN) #1 entered Resident #2's room, found the resident unresponsive, checked for a pulse and respirations and did not obtain any; however, RN #1 failed to initiate CPR according to the resident's wishes as indicated on the Advance Directives form.  The facility's failure to ensure residents' Comprehensive Care Plans were developed to	F 279	plans to incorporate code status for each resident.  The Code Status Policy was revised to incorporate instructions to add code status to residents CCPs on admission. The Code Status Policy instructs staff that upon admission to facility, the charge nurse will create care plan for resident code status that is derived from resident's advance directives.  All staff, except for four, were educated on revised code status policy between 3/31/15 and 4/16/15 by DON and ADON. The four staff members, 1 LPN and 3 CNAs, who did not receive this education, are on medical leave with an unknown date for return at this point, however, they will not be allowed on the schedule until they have completed the education that is to be conducted by DON or ADON. Furthermore, this education has been added to the facility's orientation program, for nurses, which is conducted prior to new employees providing direct care in the facility. Administrator educated, on 4/7/15, MDS staff on the need for residents' code status to be on resident care plan. Administrator also educated, on 4/7/15, MDS staff that a review of		

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F 279	<p>Continued From page 68</p> <p>Include their requested code status with interventions in place to ensure their code status was honored has caused or is likely to cause serious injury harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/07/15, and was determined to exist on 03/28/15. The facility was notified of the Immediate Jeopardy on 04/07/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15 with the facility alleging removal of the Immediate Jeopardy on 04/12/15. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on 04/12/15, prior to exit on 04/16/15, with remaining non-compliance at a Scope and Severity of a "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Resident Care Plan", dated 05/01/09, revealed the purpose of the policy was to develop a Comprehensive Care Plan for each resident which included measurable objectives and timetables to meet the needs identified. Per the Policy, the nursing care plan would be initiated within twenty-four (24) hours of admission. Continued review revealed the resident's care plan would reflect the specific needs of each resident to include physical, social, and emotional problems and concerns. The Policy revealed the services provided or arranged by the facility would meet professional standards, and qualified persons would provide services in accordance with each resident's written plan of care.</p>	F 279	<p>code status has been added to resident Care Plan Conferences beginning on 4/15/15.</p> <p>Social Worker will discuss with residents/ responsible parties during Care Plan Conferences to determine any change to advance directives. If residents/ responsible parties do not attend Care Plan Conferences, Social Worker will contact resident/ responsible party directly to determine changes to advance directives. Social Worker will document discussions in residents' chart. Social Worker will update the resident Care Plan if any changes occur. Administrator will audit Social Worker documentation to ensure Social Worker is having discussions with residents/ responsible parties regarding their advance directives. DON will conduct chart audits of all new admissions to verify resident advance directives are documented on resident chart and Care Plan. MDS staff will audit all new admissions for code status on CCP during admission assessment. Administrator audited all current resident charts on 4/9/15 to verify that code status was on all residents care plans. No issue identified. Any issues identified in the above monitors will</p>		

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F 279	Continued From page 69  1. Record review revealed the facility admitted Resident #2 on 03/25/15, with diagnoses which included a history of Myocardial Infarct (Heart Attack), Coronary Artery Bypass Graft, aftercare for a Traumatic Fracture of the Hip, and Diabetes. Review of Resident #2's "Admit/Readmit Screener" assessment, dated 03/27/15, revealed Resident #2 had provided the information for the assessment, and was noted to be alert to person and verbally appropriate. Review of the Physician's Order, dated 03/25/15, revealed an order for Resident #2 to have a Full Code status. Review of the "Code Status Consent Form" dated 03/25/15 and signed by Resident #2's Responsible Party, revealed the Responsible Party requested and consented to the use of cardiac compressions or artificial ventilation to resuscitate the resident in the event of death. However, review of the Comprehensive Care Plan (CP) for the admission date 03/25/15, revealed no documented evidence a care plan was developed for Resident #2's Advance Directives and "Full Code" status with interventions to ensure the resident's request was honored.  On 03/28/15, Resident #2 was found to be unresponsive and without signs of life by RN #1. After verifying the resident's Full Code status, RN #1 failed to initiate CPR, in contrast to Resident #2's wishes. (Refer to F155, F281 and F490)  2. Record review revealed the facility admitted Resident #1 on 02/10/15, with diagnoses which included Cerebral Embolism with Cerebral Infarction, Diabetes, Depressive Disorder and Parkinson. Review of the Admission Minimum Data Set (MDS) Assessment, dated 02/19/15,	F 279	be taken to the Quality Assurance Performance Improvement (QAPI) committee.	6/12/15

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F 279	<p>Continued From page 70</p> <p>revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) which indicated the resident was cognitively intact. Continued record review revealed Resident #1 had requested to be a "Full Code" and signed a document noting this on 02/10/15. However, review of the Comprehensive Care Plan (CP) dated 02/23/15, revealed no documented evidence a care plan was developed for Resident #1's Advance Directive and/or Full Code status with interventions to ensure the resident's request was honored.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted the resident on 08/17/12, with diagnoses which included Depression, Anxiety, Hypertension, Autoimmune Hepatitis, Diabetes and Insomnia. Review of the Quarterly MDS Assessment, dated 03/09/15, revealed the facility had assessed Resident #3 to have a BIMS score of fourteen (14) out of fifteen (15) which indicated the resident was cognitively intact. Continued record review revealed Resident #3 had Advance Directives dated 09/27/12, requesting to be a "Full Code". However, review of the Comprehensive Care Plan, dated 03/18/15, revealed no documented evidence a care plan was developed for Resident #3's Advance Directive and/or Full Code status with interventions to ensure the resident's request was honored.</p> <p>4. Review of Resident #4's medical record revealed the facility admitted the resident on 10/09/14, with diagnoses which included Mood Disorder, Chronic Airway Obstruction, Anxiety, Depressive Disorder, Hypertension and Chronic Kidney Disease. Review of the Quarterly MDS</p>	F 279			

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F 279	<p>Continued From page 71</p> <p>Assessment, dated 01/12/15, revealed the facility assessed Resident #4 as being moderately cognitively impaired, with a BIMS score of twelve (12) out of fifteen (15). Continued record review revealed Resident #4 had Advance Directives dated 10/09/14, indicating he/she did not want CPR. However, review of the Comprehensive Care Plan (CP) dated 01/15/15, revealed no documented evidence a care plan was developed for Resident #4's Advance Directive and/or Do Not Resuscitate (DNR) status with interventions to ensure the resident's request was honored.</p> <p>5. Review of Resident #5's medical record revealed the facility admitted the resident on 03/16/11, and readmitted on 09/11/13, with diagnoses which included Chronic Airway Obstruction, Hypertension, Congestive Heart Failure, Disorder of the Kidney and Ureter, Anxiety and Debility. Review of the Quarterly MDS Assessment, dated 02/02/15, revealed the facility assessed Resident #5 as being cognitively intact, with a BIMS score of fifteen (15) out of fifteen (15). Continued record review revealed Resident #5 had Advance Directives, dated 01/13/15, noting the resident did not want CPR. However, review of the Comprehensive Care Plan (CP) dated 03/13/15, revealed no documented evidence a care plan was developed for Resident #5's Advance Directive and/or DNR status with interventions to ensure the resident's request was honored.</p> <p>6. Review of Resident #6's medical record revealed the facility admitted the resident on 02/13/14, with diagnoses which included Coronary Artery Disease, Anorexia, Depression and Anxiety. Review of the Annual MDS Assessment, dated 02/16/15, revealed the facility</p>	F 279			

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F 279	<p>Continued From page 72</p> <p>assessed the resident to be moderately cognitively impaired, with a BIMS score of twelve (12) out of fifteen (15). Continued record review revealed Resident #6 had Advance Directives, dated 02/13/14, noting the resident did not want CPR. However review of the Comprehensive Care Plan (CP) dated 01/30/15, revealed no documented evidence a care plan was developed for Resident #6's Advance Directive and/or DNR status with interventions to ensure the resident's request was honored.</p> <p>7. Review of Resident #7's medical record revealed the facility admitted the resident on 10/20/14, and readmitted on 03/17/15, with diagnoses which included Methicillin Resistant Staphylococcus Aureus (MRSA) of Unspecified Site (an antibiotic resistant bacterial infection), Diabetes, Peripheral Vascular Disease, Cerebral Artery Occlusion with Infarct and Hypertension. Review of the Admission MDS Assessment, dated 03/26/15, revealed the facility assessed the resident to be cognitively intact, with a BIMS score of fifteen (15) out of fifteen (15). Continued record review revealed Resident #7 had Advance Directives dated 03/17/15, requesting to be a "Full Code". However, review of the Comprehensive Care Plan (CP) dated 03/31/15, revealed no documented evidence a care plan was developed for Resident #7's Advance Directive and/or Full Code status with Interventions to ensure the resident's request was honored until 04/07/15.</p> <p>8. Review of Resident #8's medical record revealed the facility admitted the resident on 11/25/14, and readmitted on 03/16/15, with diagnoses which included Chronic Airway Obstruction, Chronic Kidney Disease, Depressive</p>	F 279			

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NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
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F 279	<p>Continued From page 73</p> <p>Disorder, Peripheral Vascular Disease, Diabetes, and Malignant Carcinoid Tumor of the Transverse Colon. Review of the Admission MDS Assessment, dated 03/22/15, revealed the facility assessed the resident to be moderately cognitively impaired, with a BIMS score of eleven (11) out of fifteen (15). Continued record review revealed Resident #8 had Advance Directives dated 03/13/15, requesting to be a "Full Code". However, review of the Comprehensive Care Plan (CP) dated 03/24/15, revealed no documented evidence a care plan was developed for Resident #8's Advance Directive and/or Full Code status with interventions to ensure the resident's request was honored until 04/07/15.</p> <p>9. Review of Resident #9's medical record revealed the facility admitted the resident on 07/03/14, and readmitted on 09/19/14, with diagnoses which included Epilepsy, Dementia, Anxiety, Cardiovascular Disease and Chronic Kidney Disease. Review of the Admission MDS Assessment, dated 07/10/14, revealed the facility assessed the resident to be cognitively intact with a BIMS score of fifteen (15) out of fifteen (15). Continued record review revealed Resident #9 had Advance Directives dated 04/01/15, requesting to be a "Full Code". However, review of the Comprehensive Care Plan (CP) dated 03/25/15, revealed no documented evidence a care plan was developed for Resident #9's Advance Directive and/or "Full Code" status with interventions to ensure the resident's request was honored until 04/07/15.</p> <p>10. Review of Resident #10's medical record revealed the facility admitted the resident on 12/05/11, and readmitted on 05/31/12, with diagnoses which included Congestive Heart</p>	F 279		

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NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
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F 279	<p>Continued From page 74</p> <p>Failure, Osteoporosis, Depressive Disorder and Insomnia. Review of the Annual MDS Assessment, dated 09/04/14, revealed the facility assessed the resident to be cognitively intact, with a BIMS score of fifteen (15) out of fifteen (15). However, review of the Comprehensive Care Plan (CP) dated 02/17/15, revealed no documented evidence a care plan was developed for Resident #10's Advance Directive and/or Full Code status with interventions to ensure the resident's request was honored. Continued record review revealed Resident #10 changed his/her Advance Directives on 04/10/15 from a "Full Code" status to a DNR status and a care plan was developed for the DNR status at that time.</p> <p>11. Review of Resident #11's medical record revealed the facility admitted the resident on 03/16/15, with diagnoses which included Atrial Fibrillation, Coronary Artery Disease, Hypertension and Renal Insufficiency. Review of the Admision MDS Assessment, dated 03/23/15, revealed the facility assessed the resident to be cognitively intact, with a BIMS score of fifteen (15) out of fifteen (15). Continued record review revealed Resident #11 had Advance Directives effective 04/01/15, requesting to be a "Full Code". However, review of the Comprehensive Care Plan (CP) initiated on 03/17/15, revealed no documented evidence a care plan was developed for Resident #11's Advance Directive and/or Full Code status with interventions to ensure the resident's request was honored.</p> <p>12. Review of Resident #12's medical record revealed the facility admitted the resident on 08/26/11, and readmitted him/her on 06/07/12, with diagnoses which included Schizophrenia,</p>	F 279			

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F 279	<p>Continued From page 75</p> <p>Episodic Mood Disorder, Depressive Disorder and Malignant Neoplasm of the Kidney. Review of the Quarterly MDS Assessment, dated 02/02/15, revealed the facility assessed the resident to be cognitively intact, with a BIMS score of fifteen (15) out of fifteen (15). Continued record review revealed Resident #12 had Advance Directives effective 09/23/15, indicating he/she did not want CPR. However, review of the Comprehensive Care Plan (CP) dated 02/05/15, revealed no documented evidence a care plan was developed for Resident #12's Advance Directive and/or DNR status with interventions to ensure the resident's request was honored until 04/07/15.</p> <p>Interview with the MDS Coordinator, on 04/07/15 at 9:30 AM, revealed her department was responsible for resident care plans. She stated care plans were developed based on the residents' individual needs. Per interview, the resident's code status was on the resident's face sheet. Continued review revealed residents were not care planned regarding their code status. However, she stated if a resident was a Full Code, CPR was required to be performed. The MDS Coordinator acknowledged the issue was a care need for the resident and should be care planned.</p> <p>Interview with the Director of Nursing (DON), on 04/06/15 at 4:02 PM, revealed care plans were developed based on each resident's individual needs. The DON stated the residents were not currently care planned related to their code status; however, she acknowledged it was a care need and should be care planned. She further stated the facility should develop and implement care plans for every resident which included</p>	F 279		

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F 279	<p>Continued From page 76</p> <p>Interventions related to each individual's code status.</p> <p>Interview with the Administrator, on 04/06/16 at 4:30 PM, revealed facility residents, including Resident #2, were not care planned for code status. The Administrator stated interventions related to care needs in the event of a cessation of heart and/or lung function should be developed for every resident and included on the Comprehensive Care Plan.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/14/15, which alleged removal of the IJ effective 04/12/15. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> <li>1. On 03/28/15, the Director of Nursing (DON) initiated an investigation into the incident involving Resident #2. The DON interviewed (Registered Nurse) RN #1, Certified Nursing Assistant (CNA) #3 and CNA #4 regarding Resident #2 not receiving Cardiopulmonary Resuscitation (CPR) even though the resident was Full Code status. RN #1 was suspended pending the facility's investigation. On 03/30/15, an initial report of the incident involving Resident #2 on 03/28/15 was sent to the State Agency by the Social Services Director.</li> <li>2. On 03/30/15, RN #1 was terminated from her position of employment with the facility.</li> <li>3. On 03/30/15, the facility developed a Code Status Acknowledgement policy which included the procedure for a visual identification system. Full Code status residents would be identified by application of a green bracelet to the resident's</li> </ol>	F 279			

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F 279	<p>Continued From page 77</p> <p>wrist, and placement of a green sticker outside the resident's door beside their name. A resident with a Do Not Resuscitate (DNR) status would have a black sticker on the door by their name.</p> <p>4. On 03/31/15, the DON and the Assistant DON (ADON) conducted education in small group sessions to all staff (with the exception of four (4) staff on medical leave) related to their knowledge and understanding of the facility's Code Status Acknowledgement policy. Education related to the Code Status Acknowledgement policy was added to the training agenda for New Employee Orientation.</p> <p>5. On 03/31/15, Medical Records personnel conducted a review of all current residents in the facility to verify their code status.</p> <p>6. On 03/31/15 through 04/01/15, the Social Services Director (SSD) reviewed Advance Directives with all current "Full Code" status residents and/or their Power of Attorney (POA) to ensure their code status was accurate.</p> <p>7. On 04/01/15, the SSD verified the Code Status Acknowledgement policy was implemented by a visual inspection of all full code status residents to ensure each had a green bracelet on their wrist and a green sticker next to their name on the door.</p> <p>8. The SSD monitored daily beginning 04/01/15 through 04/11/15, to ensure all full code status residents continued to wear a green bracelet and had a green sticker next to their name on the outside of their door.</p> <p>9. On 04/06/15 through 04/11/15, the</p>	F 279		