

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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/23/2015
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220	
(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 05/12/15</p> <p>A Recertification/Abbreviated/Extended Survey was initiated on 04/14/15 and concluded on 04/23/15. KY 23144 and KY23098 were investigated and the Division of Health Care unsubstantiated the allegation for KY23144 and substantiated KY 23098 with Immediate Jeopardy (IJ) identified on 04/16/15 and was determined to exist on 04/14/15 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 04/16/15.</p> <p>Interview and record review revealed the facility failed to have an effective system to report abuse and implement facility policy to prevent the potential for further abuse to occur. On 04/14/15 during the resident's care plan meeting, Resident #10 reported an allegation of physical abuse involving Certified Nursing Assistant (CNA) #1. The resident stated CNA #1 threw him/her on the bed. Staff present at the meeting was aware of the requirements of the facility's Abuse Policy reporting guidelines; however, failed to report the allegation to the Director of Nursing or to the Administrator, and the CNA worked the evening shift (2:30 PM-10:30 PM) on 04/14/15 on the resident's unit.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 04/17/15 which alleged removal of the Immediate Jeopardy on 04/18/15.</p>	F 000	<p>To the best of my knowledge and belief, as an agent of Signature HealthCARE of East Louisville, the following allegation of compliance constitutes a written plan to remove the Immediate Jeopardy.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <p>Immediate Jeopardy Concern Stated: The facility failed to report and protect the resident from abuse (F225) by allowing the CNA to work the day the allegation was made. The facility failed to follow its policy by not immediately reporting an allegation of abuse to the DON or Administrator (F226).</p> <p>Resident(s) affected by the IJ and actions taken to remove IJ:</p> <p>One resident reported during a care plan meeting on 4-14-15 that a CNA on Saturday 4-11-15 had thrown her in bed and made her go to bed when she didn't want to go. An investigation was initiated on 4-15-15 (completed on 4-16-15) into the one resident allegation of abuse, led by the Administrator. Action items to remove the jeopardy are as follows:</p> <ul style="list-style-type: none"> <li>•Patient's family was aware of the allegation by the resident as they were present during the care plan meeting on 4-14-15.</li> <li>•Patient's physician was notified on 4-15-15, Dr. Carmel Person by the Administrator and DON. Dr. Person is also the Medical Director of the facility.</li> </ul>	

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

TITLE

(X6) DATE

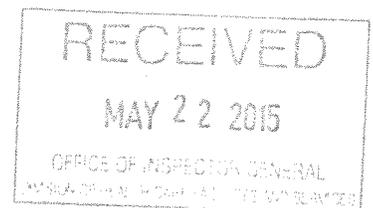
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 required to continue program participation.

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F 000	Continued From page 1 The State Survey Agency verified Immediate Jeopardy was removed on 04/18/15 as alleged prior to exit. The scope and severity was lowered to a "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.	F 000	•The patient was assessed for injury by the DON on 4-15-15. Patient condition was found to be her baseline, with no indications of changes or injuries.  •A facility investigation was initiated on 4-15-15 and reported to the Office of Inspector General and Adult Protective Services by the Administrator on 4-15-15. The investigation was concluded and unsubstantiated by the facility on 4-16-15 and a follow up report sent to the Office of Inspector General by the Administrator.		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	•The accused CNA was suspended via telephone at 12:18pm on 4-15-15 by the DON.  •The administrator interviewed the resident on 4-15-15 at 12:15pm.  •The Social Service Director, Social Service Assistant, and the Transitional Care Nurse interviewed 73 current residents with BIMS scores of 8-15 regarding abuse and choices on 4-15-15, 4-16-15 and 4-17-15. The interviews were conducted using selected questions from the Resident Interview Tool from ABAQIS. 2 additional residents voiced allegations of abuse (that were not reported to the facility previously). The first was reported to the facility late in the evening on 4/15/15. The investigation was initiated and the report was sent to the OIG and APS on the morning of 4/16/15. The second was reported to the facility on the afternoon of 4/16/15. The investigation was initiated on 4/16/15 and reported to the OIG and APS on 4/16/15. These allegations did not allege the same perpetrator.		



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F 225 Continued From page 2  
The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

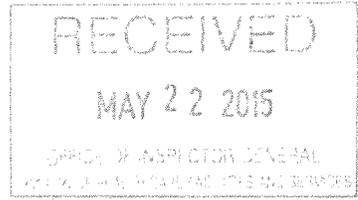
This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure the staff reported and protected one (1) of twenty-seven (27) sampled residents, (Resident #10), when staff failed to report an allegation of physical abuse to the Administrator and residents were not protected from potential further abuse.

On 04/14/15 the facility received an allegation from Resident #10 regarding physical abuse by Certified Nursing Assistant (CNA) #1 towards Resident #10. The allegation stated Resident #10 was present in a care plan meeting on 04/14/15 with the Director of Social Services, Assistant Director of Social Services, Director of Dietary, Chaplain, Quality of Life Director, Physical Therapy Assistant, Assistant Director of Nursing and two (2) family members when the resident stated CNA #1 threw him/her on the bed. Staff present at the meeting was aware of the requirements of the facility's Abuse Policy reporting guidelines; however, failed to report the allegation to the Director of Nursing or Administrator, and CNA #1 worked the evening shift (2:30 PM-10:30 PM) on 04/14/15 on the resident's unit.

F 225

- 45 of the total 118 current residents with BIMS scores of less than 8 had skin assessments completed to observe for signs of abuse by the DON, Assistant Director of Nursing, and Transitional Care Nurse on 4-15-15, 4-16-15 and 4-17-15; no observations of abuse were detected. 45 attempts were made to contact residents' responsible parties by social services director, social services assistant, Medical Records Nurse and Transitional care nurse.
- A resident council meeting to be held on 4/17/2015 to discuss abuse reporting, the facility's obligation to report and how we are going to remedy our deficient practice.
- A facility QAPI meeting was held on 4-15-15 with the Medical Director, DON, Administrator, Social Service Director, Social Service Assistant, and Administrator in Training. A summary of the alleged event was given to the QAPI team. The facility's abuse policy was reviewed with no changes made to the policy. Dr. Person reviewed the resident's chart with no changes made.

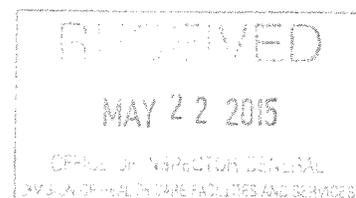
Training:  
On 4-15-15 at 11:15am immediate education was provided to the Social Service Director, Social Service Assistant, Activity Director, Physical Therapy Assistant, and the Assistant Director of Nursing on 200 who attended the care plan meeting on 4-14-15 using the Abuse policy by the Director of Clinical Risk Management and the Administrator. Also included in this training were the DON and the Administrator in Training.



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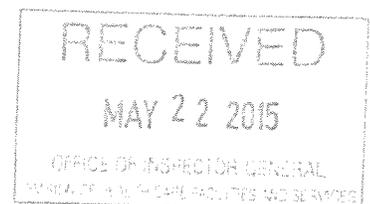
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F 225	Continued From page 3  The facility's failure to report and allegation of abuse and to protect residents from potential abuse after an allegation of abuse was reported to staff placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 04/16/15 and determined to exist on 04/14/15. The facility was notified of the Immediate Jeopardy on 04/16/15.  The facility provided an acceptable Allegation of Compliance (AOC) on 04/17/15 which alleged removal of the Immediate Jeopardy on 04/18/15. The State Survey Agency verified Immediate Jeopardy was removed on 04/18/15 as alleged prior to exit. The scope and severity was lowered to a "D" in 42 CFR 483.13 Resident Behavior and Facility Practices (F225) while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.  The findings include:  Review of the facility's Abuse Policy, dated April 2013, revealed all allegations of abuse were to be reported immediately. Residents and families would be educated on signs of abuse and the reporting process. The name and phone numbers of reporting agencies would be posted. All abuse allegations would be investigated. Social Services and the Chaplain would follow up with the resident to monitor their emotional well-being.  Review of the clinical record of Resident #1 revealed the facility admitted the resident on 08/27/14 with diagnoses of Left Cerebrovascular Accident, Chronic Pain, Visual loss (right eye), Ulcerative Colitis, Insomnia, Alcohol Abuse and	F 225	On 4-15-15 at 12:45pm education was provided to Transitional Care Nurse, MDS x 2, Maintenance Director, Assistant Directors of Nursing on 100 and 300, Business Office Manager, Admissions, Housekeeping Manager, Chaplin, Respiratory Therapist, Director of Human Resources, Dining Services Manager (who was present during the care plan meeting), Staff Development Coordinator, Rehab Services Manager, and Medical Records using the Abuse policy by the Director of Clinical Risk Management.  Current staff education was begun on 4-15-15 and completed on 4-17-15 on 163 out of 166 employees on the Abuse policy by the Administrator, DON, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing on 200, Transitional Care Nurse, MDS x 2, Maintenance Director, Assistant Directors of Nursing on 100 and 300, Business Office Manager, Admissions, Housekeeping Manager, Chaplin, Respiratory Therapist, Director of Human Resources, Dining Services Manager, Staff Development Coordinator, Rehab Services Manager, Medical Records, RD and RN Supervisor.  Post education competencies were completed by all staff after receiving the education. Staff on vacation or leave of absence will not be allowed to return to work until their education and post education competency is completed.  This education was provided to 163 of the 166 employees in all departments including administration, LPNs, RNs, CNAs, Dietary, Housckeping, Therapy, Laundry, Activities, Social Services and Maintenance. There are 3 staff members on vacation that we will not let work until the training is obtained and posttest competencies completed. The Staff Development Coordinator will educate all new hires prior to starting department orientation. This facility does not utilize agency staff.		



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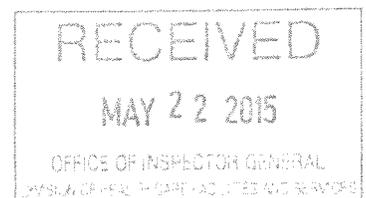
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F 225	<p>Continued From page 4</p> <p>Hypertension. The facility completed an initial Minimum Data Set (MDS) on 09/03/14 and assessed the resident using a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) out of fifteen (15), which meant the resident was interviewable.</p> <p>Interview with Resident #10, on 04/15/15 at 9:45 AM, revealed on 04/14/15 during the resident's Care Plan Meeting, he/she reported CNA #1 threw the resident on the bed after the resident's shower on 04/11/15.</p> <p>On 04/15/15, following the resident interview at 9:45 AM, the Administrator was immediately notified by the State Survey Agency of the allegation of physical abuse alleged by Resident #10. The Administrator stated he had no knowledge of the allegation until it was reported to him by a State Surveyor. Upon notification CNA #1 was suspended immediately by the Director of Nursing (DON) and the investigation was initiated by the Administrator and DSS.</p> <p>Review of the facility's investigation, dated 04/15/15, revealed Resident #10 alleged that after the resident's shower, CNA #1 threw him/her in to the bed and he/she did not want to go. The resident stated the CNA stood him/her up and put him/her in bed on the resident's stroke side. The resident denied any injury and stated he/she did not hurt anywhere from the incident. The staff attending the Care Plan Meeting were interviewed as well as the alleged perpetrator. It further revealed the CNA was suspended by the DON, and the resident was interviewed during the skin assessment to determine any injury. The facility unsubstantiated the allegation. Neither the facility nor the State Survey Agency could verify the date</p>	F 225	<p>Monitoring:</p> <p>Effective 4/17/15, all facility care plan meetings will be attended by the Administrator, Administrator in Training, DON, or one of the 2 MDS Nurses. The next scheduled care plan meeting is 4/21/15. These individuals will monitor the communication from the family and/or the resident to insure allegations of abuse are reported and acted upon per the Abuse policy.</p>		
F 225			<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>DON assessed identified resident for injury on 4/15/15 with no injury noted. Resident's physician was notified on 4/15/15 by Administrator and DON. Investigation was initiated on 4/15/15 by the administrator and concluded on 4/16/15 and found to be unsubstantiated. During the investigation, the identified employee was suspended.</p> <p>How will the facility identify other residents that have the potential to be affected?</p> <p>All residents with BIMs of 8 or greater were interviewed by the social services team regarding abuse. All interviews (73 total) were completed by 4/17/15. As a result of this, 2 additional allegations were reported to the administrator, investigated by the facility and were unsubstantiated by the facility and OIG.</p> <p>All residents with BIMs 7 or lower had a skin assessment completed (45 total) by DON, ADONs and Transitional Care Nurse. These audits were completed by 4/17/15. No additional residents were identified.</p>	5/14/15	



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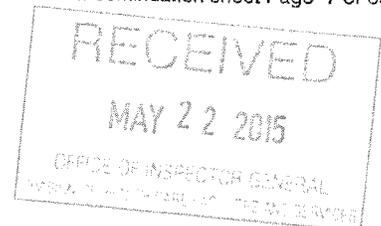
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F 225	<p>Continued From page 5</p> <p>the alleged allegation occurred based on the facility's staffing schedule and ADL schedule.</p> <p>Interviews with the Care Plan Team, on 04/15/15 at 10:25 AM with the Director of Social Services (DSS); at 10:35 AM with the Assistant Director of Social Services Director (ASSD); at 10:40 AM with the 200 Unit Assistant Director of Nursing (ADON); at 2:25 PM with the Dietary Director (DD); at 2:30 PM with the Quality of Life Director (QLD); at 2:50 PM with the Physical Therapy Assistant (PTA); via telephone, on 04/20/15 at 2:40 PM, with Family Member #1; and, on 04/21/15 at 8:20 AM, with Family Member #2 revealed they were all present at the Care Plan meeting and heard Resident #10 state CNA #1 threw him/her on the bed. In addition, staff members and family members revealed during their interviews, the Administrator had not been notified of the allegation because the ADON stated during the meeting she would take care of it; however, the ADON did not notify the Director of Nursing or Administrator, who were in the facility at the time.</p> <p>Interview with the 200 Unit ADON, on 04/15/15 at 3:05 PM, revealed the resident reported CNA #1 threw the resident onto the bed after a shower on Saturday. She further stated the report was received during the care plan meeting on 04/14/15 but she did not report it to the Administrator or DON on 04/14/15 before she left the building for the night. She stated she should have reported the allegation to ensure resident safety before she left the building. Per interview, she had to leave for an appointment and could not stay to report the allegation.</p> <p>A second interview with the 200 Unit ADON, on</p>	F 225	<p><b>What measures will be put into place to ensure that the deficient practice will not recur?</b></p> <p>Facility has posted signage throughout the building, including break room, corridors, nurses' stations and entrances reminding staff, vendors and visitors how to immediately report suspected abuse.</p> <p>All grievances will be reviewed for allegations of abuse daily Monday through Friday by the Administrator, Administrator in Training and/or DON and daily on the weekend by the manager on duty.</p> <p>Care plans x4 weeks will be attended by the Administrator, Administrator in Training, DON or one of the 2 MDS Nurses to insure allegations of abuse are reported and acted upon per the Abuse policy. Then weekly 50% of care plans will be attended by the Administrator, Administrator in Training, DON, Transitional Care Nurse or one of the 2 MDS Nurses x 4 weeks. Then weekly, 25% of care plans will be attended by the Administrator, Administrator in Training, DON, Transitional Care Nurse or one of the 2 MDS Nurses x 4 weeks.</p> <p><b>How the facility will monitor its performance to ensure solutions are sustained.</b></p> <p>The abuse interviews (conducted by Social services and Administrator in training) and skin assessments (conducted by DON and ADONs) will be completed on 25% weekly x 4 weeks, then 25% monthly x 3 months, then 25% quarterly thereafter. The administrator will review the results of the abuse interviews and skin assessments weekly x4 weeks, then monthly x 3 months, then quarterly thereafter. The results of the audits will be presented to the QAPI team by the Admin and DON weekly for 4 weeks, monthly x 3 months and then quarterly thereafter for review and recommendation based upon the results.</p>		



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F 225	<p>Continued From page 6</p> <p>04/15/15 at 4:20 PM, revealed she sent a text message to the DON, on 04/14/15 at 6:26 PM, telling him they needed to set-up a meeting with the CNA and Resident #10 due to a complaint made during the care plan meeting. However, the message did not include there was an allegation of physical abuse. However, the DON did not respond to the text. Interview with the DON, on 04/15/15 at 10:20 AM, revealed he confirmed he did not respond to the text message; however did not explain as to why.</p> <p>Review of both cell phone messages provided by the staff during survey revealed, the ADON and DON both had the text messages, dated 04/14/15, timed at 6:26 PM, present on their cell phones, which stated, "See if you can set up a meeting with me, CNA #1, Resident #10 and his/her family had a complaint against him today in the care plan meeting".</p> <p>Review of the staffing schedule, dated 04/14/14, revealed CNA #1 worked 2:30 PM until 10:30 PM on the 200 Unit where Resident #10 resided, after the allegation was made in the care plan meeting.</p> <p>Interview with the Administrator, on 04/15/15 at 5:00 PM, revealed he was made aware of the abuse allegation by the survey team, Resident #10 reported to the care plan team, that CNA #1 threw him/her on the bed. Statements were taken from the staff in attendance at the care plan meeting. Interviews were completed with the residents. He further stated the staff should have reported the allegation to him, and further stated by leaving the CNA in the building to work placed all the residents at risk for abuse.</p> <p>The facility took the following actions to remove</p>	F 225			



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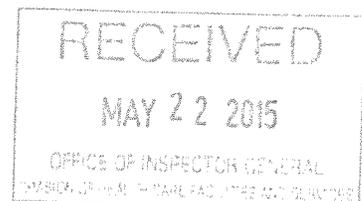
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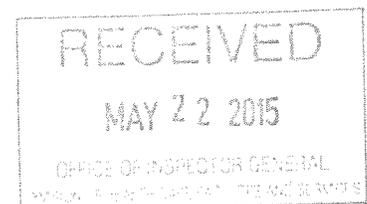
F 225	<p>Continued From page 7 the Immediate Jeopardy as follows:</p> <ol style="list-style-type: none"> <li>1. The resident's family was aware of the allegation made by the resident as they attended the care plan meeting when the allegation was made on 04/14/15.</li> <li>2. The resident's Physician/Medical Director was notified of the allegation on 04/15/15 by the DON, with no injury identified.</li> <li>3. The DON assessed the resident for injury on 04/15/15.</li> <li>4. An investigation was initiated on 04/15/15 when the Administrator was notified. Regulating agencies were notified Office of the Inspector General (OIG) and Adult Protective Services (APS). The investigation was concluded and unsubstantiated on 04/16/15 and a follow-up report was sent to OIG.</li> <li>5. The DON suspended CNA #1 on 04/15/15 at 12:18 PM.</li> <li>6. The Administrator interviewed Resident #10, on 04/15/15 at 12:15 PM.</li> <li>7. On 04/15/15, 04/16/15, and 04/17/15 Staff assigned to complete resident interviews were the Director of Social Services, Assistant Director of Social Services, and the Transitional Care Nurse/Staff Development. An Abaqis tool (a Quality Assurance tool) was used to interview seventy-three (73) residents with BIMS scores eight (8) to fifteen (15) regarding abuse and choices.</li> <li>8. On 04/15/15, 04/16/15, and 04/17/15 forty-five</li> </ol>	F 225		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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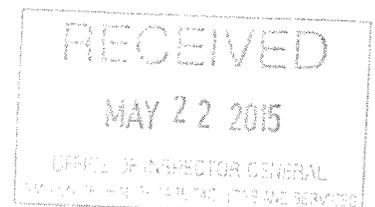
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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F 225	Continued From page 8 (45) residents with BIMS scores zero (0) to eight (8) had skin assessments completed to observe for signs of abuse, there were no signs of abuse identified. The skin assessments were completed by the Director of Nursing, Assistant Director of Nursing, and Staff Development. The Director of Social Services and Assistant Director of Social Services, Medical Records Nurse and Staff Development made forty-five (45) calls to responsible parties of residents with BIMS of eight (8) or less, contact was made with thirty (30) responsible parties who voiced no care concerns.  9. On 04/17/15 a Resident Council Meeting was held by the Administrator to discuss abuse reporting, the facility's obligation to report, and how the facility would remedy the deficient practice.  10. On 04/15/15 a Quality Assurance Performance Improvement (QAPI) Committee meeting was held, in attendance: Medical Director, Director of Nursing, Administrator, Director of Social Services, Assistant Director of Social Services, and the Administrator in Training discussed the alleged event, reviewed the abuse Policy (no changes), and the Medical Director reviewed Resident #10's chart with no orders.  11. On 04/15/15 at 11:15 AM, immediate education was provided to the Administrator regarding the Abuse policy, by the Clinical Risk Manager. Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Physical Therapy Assistant, Assistant Director of Nursing (3), Director of Nursing, and Administrator in Training received training by the Clinical Risk Manager and the Administrator regarding the Abuse Policy.	F 225			



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

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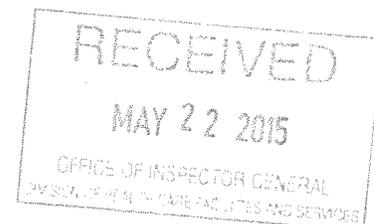
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F 225	Continued From page 9  12. On 04/15/15 at 12:45 PM, the Abuse Policy was used by the Clinical Risk Manager to educate the following: Minimum Data Assessment Nurses (2), Maintenance Director, Assistant Director of Nurses (3), Business Office manager, Admissions, Housekeeping Manager, Chaplain, Respiratory Therapist, Director of Human Resources, the Dining Services Director, Transitional Care Nurse/Staff Development, Rehabilitation Services Manager, and Medical Records.  13. Education was provided by the Administrator, Director of Nursing, Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Assistant Director of Nursings (3), Staff Development, Medical Director, Business Office Manager, Administrator, Housekeeping, Chaplain, Respiratory Therapist, Human Resources, Dietary Manager, Rehabilitation Manager, Medical Records, Dietitian, and RN Supervisor, on 04/15/15 thru 04/17/15 to the current staff. The current staff totaled one hundred and sixty-three (163) out of one hundred and sixty-six (166) employees on the Abuse Policy.  14. Post education tests were provided and graded by the Administrator, Director of Nursing, Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Assistant Director of Nursing (3), Staff Development, Medical Director, Business Office Manager, Admissions, Housekeeping, Chaplain, Respiratory Therapist, Human Resources, Dietary Manager, Rehabilitation Manager, Medical Records, Dietitian, and RN Supervisor after education was completed by all staff. Staff	F 225			



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

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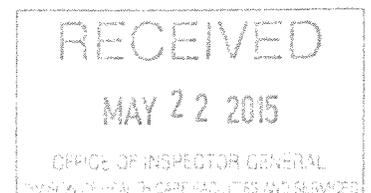
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F 225	<p>Continued From page 10</p> <p>on vacation or leave of absence would not be allowed to work until abuse education was completed.</p> <p>15. The Staff Development would educate all new hires on abuse prior to starting their department orientation.</p> <p>16. Effective 04/17/15 all Care Plan Meetings would be attended by the Administrator, Administrator in Training, Director of Nursing, or one of the two (2) MDS nurses. The next Care Plan Meeting is 04/21/15. Assigned staff will monitor feed back from residents and families.</p> <p>17. Beginning 04/21/15, once a week 25% of residents with BIMS scores eight (8) or greater will be interviewed by the department head or interdisciplinary team regarding abuse. Also, 25% of residents with BIMS scores of below eight (8) will have skin assessments completed by nursing management.</p> <p>18. There will be weekly QAPI meetings to review trending data with interviews, assessment and Care Plan Meetings, beginning 04/21/15.</p> <p>The State Survey Agency validated the removal of the Immediate Jeopardy on 04/23/15 prior to exit as follows:</p> <p>1. Interview with Family Member #1, on 04/20/15 at 2:40 PM, revealed he/she was present in the Care Plan meeting, heard the allegation and confirmed this knowledge with the facility.</p> <p>Interview with Family Member #2, on 04/21/15 at 8:20 AM, revealed he/she was present in the Care Plan meeting and did not hear the</p>	F 225			



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

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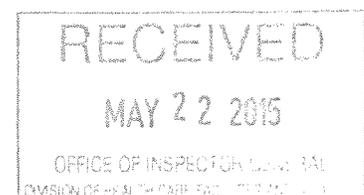
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F 225	Continued From page 11 allegation.  2. Interview with the Medical Director, on 04/15/15 at 1:15 PM, revealed she was notified of the abuse allegation by the Administrator and DON on 04/15/15 at 9:50 PM.  3. Interview, on 04/15/15 at 10:02 AM, and review of the skin assessment, revealed the DON assessed Resident #10 for possible injuries related to the allegation. The assessment was documented on a CNA Skin Care Sheet. No injuries were found.  4. Interview with the Administrator, on 04/15/15 at 1:41 PM, and review of the facility's notification to OIG and APS by fax revealed the allegation of abuse was reported and the investigation was initiated by the Administrator. On 04/16/15 at 7:32 PM a follow-up report of a completed investigation was faxed to OIG and APS.  5. Review of the Stakeholder Suspension Form, dated 04/15/15, revealed on 04/15/15 CNA #1 was suspended per a conference call by the DON. The Stakeholder Suspension Form was witnessed by the DON, HR, and ADM.  6. Interview with the ADM, on 04/21/15 at 1:30 PM, revealed he met with Resident #10 on 04/15/15 at 12:15 PM and he/she confirmed during the Care Plan meeting he/she stated CNA #1 threw him/her on the bed on 04/11/15.  7. Review of seventy-three (73) interview forms revealed on 04/15/15 thru 04/17/15 Abuse interviews were completed with seventy-three (73) residents with BIMS scores eight (8) to fifteen (15).	F 225			



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

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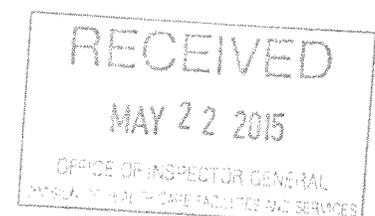
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F 225	<p>Continued From page 12</p> <p>Interviews with two (2) unsampled residents, Unsampled Resident A on 04/21/15 at 9:38 AM, Unsampled Resident B on 04/21/15 at 9:46 AM, and on 04/21/15 at 10:15 AM with Resident #10, revealed resident abuse interviews were conducted by the Director of Social Services and the Assistant Director of Social Services.</p> <p>8. Review of the BIMS roster revealed on 04/22/15 a total of forty-five (45) of a one hundred and eighteen census (118) had BIMS scores less than eight (8). Review of the forty-five (45) skin assessment revealed all of these residents had skin assessments completed by the Assistant Director of Nursing, Staff Development, and Director of Nursing on 04/15/15 thru 04/17/15.</p> <p>Review of the spread sheet to document the phone calls revealed the Director of Social Services and the Assistant Director of Social Services, Medical Records Nurse and Staff Development made forty-five (45) attempts to contact responsible parties for abuse concerns. Thirty (30) of the forty-five (45) responsible parties were contacted with no voiced concerns of abuse.</p> <p>Interviews, on 04/22/15 with four (4) random responsible parties for Unsampled Resident J at 1:40 PM; at 1:43 PM for Unsampled Resident K; at 1:45 PM for Unsampled Resident L, and at 1:48 PM for Unsampled Resident M, verified they were called by the facility and they voiced no concerns related to abuse.</p> <p>9. Review of the Resident Council Minutes, revealed on 04/17/15 at 5:00 PM, a Special Resident Council Meeting was held by the ADM</p>	F 225		



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

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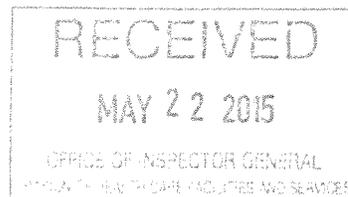
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F 225	<p>Continued From page 13</p> <p>to discuss the allegation and the importance of reporting abuse and the action the facility would initiate to remedy the deficient practice.</p> <p>Interview with the Administrator, on 04/22/15 at 3:08 PM, revealed during the Special Resident Council meeting he explained the deficient practice (IJ), encouraged the Council to report any suspected abuse, and explained how the deficiency would be corrected.</p> <p>Interviews with Unsampled Resident C, on 04/22/15 at 2:25 PM, Unsampled Resident E, on 04/22/15 at 2:40 PM, and Unsampled Resident D, on 04/22/15 at 2:47 PM, revealed there was a Special Resident Council Meeting on 04/17/15 with the ADM to discuss the survey, abuse reporting, obligations to report abuse, and how to remedy the deficient practice.</p> <p>10. A QAPI meeting was held on 04/15/15 to discuss the allegation, review the Abuse Policy, and the Medical Director reviewed Resident #10's chart with no orders given.</p> <p>Review of the QAPI meeting sign-in sheet revealed the following were present: Medical Director, Director of Social Services, Assistant Director of Social Services, Administrator in Training, DON, and the Administrator.</p> <p>Review of the medical record for Resident #10 revealed no new orders written related to the allegation of abuse.</p> <p>Interview with the ADM, on 04/22/15 at 2:25 PM, revealed in the QAPI meeting on 04/15/15, a summary of the alleged event was verbally</p>	F 225			



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

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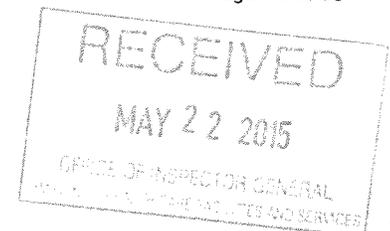
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F 225	<p>Continued From page 14</p> <p>presented to the QAPI team. The Abuse Policy, dated March 2013, was reviewed with no changes. The Medical Director reviewed the chart of Resident #10, no orders were written.</p> <p>Interview with the Medical Director, on 04/22/15 at 2:32 PM, revealed she attended the QAPI meeting with review of Resident #10's medical record and medications with no new orders, and they reviewed the Abuse Policy with no changes. The ADM reviewed the allegation event with the team.</p> <p>11. Review of the Abuse in-service sign-in sheet lead by the Clinical Risk Manager and the Administrator, on 04/15/15 at 11:15 AM, revealed the Quality of Life Director, Assistant Social Services Director, Director of Social Services, Physical Therapy Assistant, and 200 Unit ADON who were present at the care plan meeting at the time Resident #10 made an allegation of physical abuse were in-serviced on the abuse policy. The Administrator in Training and Director of Nursing were also educated at this meeting.</p> <p>Interview with the Administrator, on 04/21/15 at 1:12 PM, revealed he and the Corporate Director of Clinical Risk Management immediately in-serviced the Quality of Life Director, Assistant Director of Social Services, Director of Social Services, Physical Therapy Assistant, and 200 Unit Assistant Director of Nursing who were present at the care plan meeting and also the Administrator in Training and Director of Nursing.</p> <p>Interview with the Clinical Risk Manager, on 04/21/15 at 2:40 PM, revealed she in-serviced the Administrator prior to him assisting with training on 04/15/15.</p>	F 225			



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

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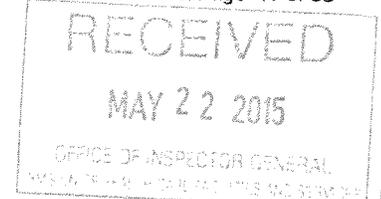
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F 225	Continued From page 15  Interview with the Quality of Life Director, on 04/21/15 at 3:30 PM, revealed she was trained by the Administrator and Clinical Risk Manager and could state the reporting process.  Interview with the Director of Social Services, on 04/21/15 at 3:34 PM, revealed she was trained by the Administrator and Clinical Risk Manager and could state the reporting process.  Interview with the Assistant Director of Social Services, on 04/21/15 at 3:49 PM, revealed she was trained by the Administrator and Clinical Risk Manager and could state the reporting process.  12. Review of the Abuse in-service sign-in sheet lead by Clinical Risk Manager on 04/15/15 revealed, Staff Development, MDS nurses (#1 and #2), Maintenance Director, ADON's (100 and 300 units), Business Office Manager, Admissions, Housekeeping Manager, Chaplain, Respiratory Therapist, Director Human Resources, Dining Services Manager, Rehabilitation Services Manager, and Medical Records were present in the training.  Interviews on 04/21/15 revealed the following stated they were educated on 04/15/15; Staff Development at 2:15 PM; Dining Service Manager at 2:25 PM; Business Office Manager at 2:30 PM; MDS #2 at 2:50 PM; Maintenance Director at 2:55 PM; Respiratory Therapist at 2:58 PM; Human Resource Director at 3:00 PM; House Keeping Supervisor at 2:15 PM; 100 Unit ADON at 3:17 PM; Rehabilitation Manager at 3:19 PM; Admissions Director at 3:21 PM; Medical Records at 3:21 PM; and, the 300 Unit ADON at 3:45 PM.	F 225			



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

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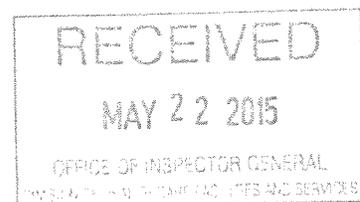
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F 225	Continued From page 16  13. On 04/15/15 thru 04/17/15 current staff were educated on the Abuse Policy. The educators were the Administrator, Director of Nursing, Assistant Director of Nurses (3), Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Staff Development, MDS (#1 and #2), Maintenance Director, Business Office Director, Admissions, Housekeeping Manager, Chaplain, Respiratory Therapist, Director of Human Resources, Dining Services Manager, Rehabilitation Manager, Medical Records, Registered Nurse Supervisor, and Dietitian.  Interviews on 04/21/15 revealed the following stated 100% of their staff was in-serviced on abuse: Administrator at 1:12 PM, Director of Social Services at 1:40 PM, Assistant Director of Social Services at 1:50 PM, MDS #1 at 1:55 PM, Chaplain 2:10 PM, Staff Development at 2:15 PM, Dining Services Manager at 2:25 PM, Business Office Manager at 2:30 PM, Quality of Life Director at 2:45 PM, MDS #2 at 2:50 PM, Maintenance Director at 2:55 PM, Respiratory Therapist at 2:58 PM, Human Resource Director at 3:00 PM, Director of Nursing at 3:10 PM, Housekeeping Director at 3:15 PM, 100 Unit ADON at 3:17 PM, Rehabilitation Manager at 3:19 PM, Admissions at 3:21 PM, Medical Records at 3:23 PM, 300 Unit ADON at 3:45 PM, ADON 200 unit at 3:48 PM, and, on 04/22/15 telephone interviews with the Dietitian at 9:40 AM and the Registered Nurse Supervisor at 10:00 AM.  Interviews on 04/21/15 with PTA #1 at 1:30 PM; on 04/22/15 with LPN #7 at 10:05 AM; LPN #6 at 10:10 AM; RN #3 at 10:15 AM; CNA #11 at 10:30	F 225			



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

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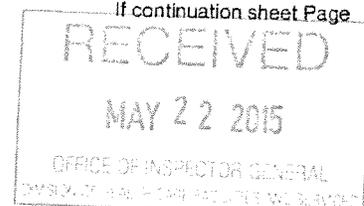
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F 225	<p>Continued From page 17</p> <p>AM; Dietary Aide #1 at 10:40 AM; SLP #1 at 10:45 AM; Housekeeper #3 at 10:50 AM; CNA #10 at 10:52 AM; CNA/CMT #9 at 10:55 AM; and, CNA #8 at 11:00 AM revealed they had all be trained on the Abuse policy and were able to voice their responsibility for reporting allegation of abuse to the Administrator.</p> <p>14. Review of 166 post tests on 04/21/15 revealed all 166 of the facility staff members had abuse in-services and completed the post test.</p> <p>15. Interview with Human Resources, on 04/22/15 at 3:50 PM, revealed there had been no new hires from 04/15/15 through 04/22/15.</p> <p>16. Interview with the Administrator, on 04/22/15 at 3:39 PM, revealed all future Care Plan Meetings would have assigned staff Administrator, Director of Nursing, MDS (#1 and #2), or Administrator in Training at all meetings.</p> <p>Review of the Care Plan Conference Summary revealed there were three (3) Care Plan Meetings on 04/21/15. At the first meeting the DON and MDS #1 were present. MDS #1 was present at the second and third meetings.</p> <p>17. Review of the Abuse Assessment and Skin Assessments, dated 04/21/15, revealed twenty (20) abuse assessments were completed for residents with BIMS scores of eight (8) to fifteen (15) by the Administrator in Training and five (5) skin assessments were completed for residents with a BIMS scores of zero (0) to eight (8) by the 100 Unit ADON.</p> <p>Interview on 04/22/15 with Resident #19 at 9:30 AM, Unsampld Resident N at 9:25 AM,</p>	F 225			



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

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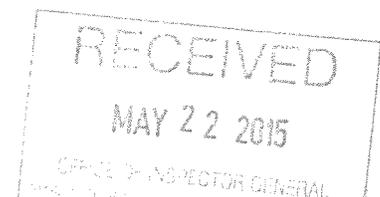
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F 225	Continued From page 18 Unsamped Resident O at 9:35 AM, Unsamped Resident Q at 9:55 AM, Unsamped Resident R at 10:00 AM, Unsamped Resident #S at 10:40 AM, Unsamped Resident #T at 10:50 AM, revealed staff had completed an abuse assessments.  Interview with the ADM, on 04/22/15 at 3:49 PM, revealed the facility would complete weekly abuse assessments for 25% of the residents with a BIMS score eight (8) to fifteen (15) and 25% skin assessment for residents with BIMS scores of zero (0) to eight (8).  18. Review of the QAPI minutes, on 04/22/15, revealed the facility had a QAPI meeting on 04/22/15 and discussed the actions put in place to correct the deficient practice. The minutes reflected five (5) skin assessments were complete and twenty (20) abuse assessments were completed so far.  Interview with the Administrator, on 04/22/15 3:49 PM, revealed weekly QAPI meetings would be held to track and trend any abuse concerns.		Immediate Jeopardy Concern Stated: The facility failed to report and protect the resident from abuse (F225) by allowing the CNA to work the day the allegation was made. The facility failed to follow its policy by not immediately reporting an allegation of abuse to the DON or Administrator (F226).  Resident(s) affected by the IJ and actions taken to remove IJ:  One resident reported during a care plan meeting on 4-14-15 that a CNA on Saturday 4-11-15 had thrown her in bed and made her go to bed when she didn't want to go. An investigation was initiated on 4-15-15 (completed on 4-16-15) into the one resident allegation of abuse, led by the Administrator. Action items to remove the jeopardy are as follows:  •Patient's family was aware of the allegation by the resident as they were present during the care plan meeting on 4-14-15.  •Patient's physician was notified on 4-15-15, Dr. Carmel Person by the Administrator and DON. Dr. Person is also the Medical Director of the facility.	
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility	F 226	•The patient was assessed for injury by the DON on 4-15-15. Patient condition was found to be her baseline, with no indications of changes or injuries.  •A facility investigation was initiated on 4-15-15 and reported to the Office of Inspector General and Adult Protective Services by the Administrator on 4-15-15. The investigation was concluded and unsubstantiated by the facility on 4-16-15 and a follow up report sent to the Office of Inspector General by the Administrator.  •The accused CNA was suspended via telephone at 12:18pm on 4-15-15 by the DON. •The administrator interviewed the resident on 4-15-15 at 12:15pm.	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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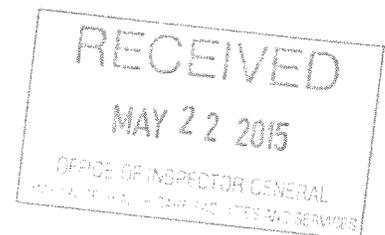
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F 226	<p>Continued From page 19</p> <p>failed to have an effective system to ensure the staff followed it's Abuse Policy to report and protect one (1) of twenty-seven (27) sampled residents (Resident #10) when it failed to report an allegation of physical abuse.</p> <p>On 04/14/15 during the resident's care plan meeting, Resident #10 reported an allegation of physical abuse involving Certified Nursing Assistant (CNA) #1. The resident stated CNA #1 threw him/her on the bed. Staff present at the meeting was aware of the requirements of the facility's Abuse Policy reporting guidelines; however, failed to report the allegation to the Director of Nursing or to the Administrator, and the CNA worked the evening shift (2:30 PM-10:30 PM) on 04/14/15 on the resident's unit.</p> <p>The facility's failure to ensure policy and procedures were implemented to ensure an allegation of abuse was reported and residents were protected from further abuse placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 04/16/15 and determined to exist on 04/14/15. The facility was notified of the Immediate Jeopardy on 04/16/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 04/17/15 which alleged removal of the Immediate Jeopardy on 04/18/15. The State Survey Agency verified Immediate Jeopardy was removed on 04/18/15 as alleged prior to exit. The scope and severity was lowered to a "D" in 42 CFR 483.13 Resident Behavior and Facility Practices (F226) while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and</p>	F 226	<ul style="list-style-type: none"> <li>•The Social Service Director, Social Service Assistant, and the Transitional Care Nurse interviewed 73 current residents with BIMS scores of 8-15 regarding abuse and choices on 4-15-15, 4-16-15 and 4-17-15. The interviews were conducted using selected questions from the Resident Interview Tool from ABAQIS. 2 additional residents voiced allegations of abuse (that were not reported to the facility previously). The first was reported to the facility late in the evening on 4/15/15. The investigation was initiated and the report was sent to the OIG and APS on the morning of 4/16/15. The second was reported to the facility on the afternoon of 4/16/15. The investigation was initiated on 4/16/15 and reported to the OIG and APS on 4/16/15. These allegations did not allege the same perpetrator.</li> <li>•45 of the total 118 current residents with BIMS scores of less than 8 had skin assessments completed to observe for signs of abuse by the DON, Assistant Director of Nursing, and Transitional Care Nurse on 4-15-15, 4-16-15 and 4-17-15; no observations of abuse were detected. 45 attempts were made to contact residents' responsible parties by social services director, social services assistant, Medical Records Nurse and Transitional care nurse.</li> <li>•A resident council meeting to be held on 4/17/2015 to discuss abuse reporting, the facility's obligation to report and how we are going to remedy our deficient practice.</li> <li>•A facility QAPI meeting was held on 4-15-15 with the Medical Director, DON, Administrator, Social Service Director, Social Service Assistant, and Administrator in Training. A summary of the alleged event was given to the QAPI team. The facility's abuse policy was reviewed with no changes made to the policy. Dr. Person reviewed the resident's chart with no changes made.</li> </ul>		



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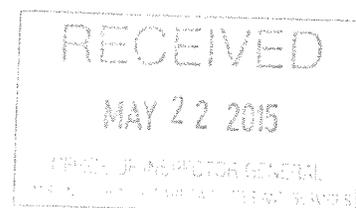
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F 226	<p>Continued From page 20 quality assurance.</p> <p>The findings include:</p> <p>Review of the Abuse Policy, dated April 2013, revealed all allegations of abuse were to be reported immediately to the charge nurse. If the charge nurse was the suspected perpetrator the allegation would be reported to another licensed nurse and/or manager in the facility, or via phone. The charge nurse would immediately remove the suspected perpetrator from resident care areas, obtain the staff member's witness statement and immediately suspend the employee pending the outcome of the investigation. The charge nurse would immediately notify the Administrator, DON and/or Abuse Coordinator as appropriate.</p> <p>Interview with Resident #10, on 04/15/15 at 9:45 AM, revealed on 04/14/15 during the resident's care plan meeting he/she reported CNA #1 had thrown the resident on the bed after the resident's shower.</p> <p>On 04/15/15 at 9:45 AM, the State Survey Agency reported the allegation to the Administrator after being informed by the resident of the allegation during interview.</p> <p>Interview with the Administrator, on 04/15/15 at 9:45 AM, revealed he had no knowledge of the allegation until it was reported to him by a State Surveyor.</p> <p>Review of the Care Plan Summary revealed, on 04/14/15 at 1:00 PM, the facility held a Care Plan Meeting for Resident #10 and family members. Present at the Care Plan Meeting were the Director of Social Services (DSS), the Assistant</p>	F 226	<p>Training:</p> <p>On 4-15-15 at 11:15am immediate education was provided to the Social Service Director, Social Service Assistant, Activity Director, Physical Therapy Assistant, and the Assistant Director of Nursing on 200 who attended the care plan meeting on 4-14-15 using the Abuse policy by the Director of Clinical Risk Management and the Administrator. Also included in this training were the DON and the Administrator in Training.</p> <p>On 4-15-15 at 12:45pm education was provided to Transitional Care Nurse, MDS x 2, Maintenance Director, Assistant Directors of Nursing on 100 and 300, Business Office Manager, Admissions, Housekeeping Manager, Chaplin, Respiratory Therapist, Director of Human Resources, Dining Services Manager (who was present during the care plan meeting), Staff Development Coordinator, Rehab Services Manager, and Medical Records using the Abuse policy by the Director of Clinical Risk Management.</p> <p>Current staff education was begun on 4-15-15 and completed on 4-17-15 on 163 out of 166 employees on the Abuse policy by the Administrator, DON, Social Service Director, Social Service Assistant, Activity Director, Assistant Director of Nursing on 200, Transitional Care Nurse, MDS x 2, Maintenance Director, Assistant Directors of Nursing on 100 and 300, Business Office Manager, Admissions, Housekeeping Manager, Chaplin, Respiratory Therapist, Director of Human Resources, Dining Services Manager, Staff Development Coordinator, Rehab Services Manager, Medical Records, RD and RN Supervisor.</p> <p>Post education competencies were completed by all staff after receiving the education. Staff on vacation or leave of absence will not be allowed to return to work until their education and post education competency is completed.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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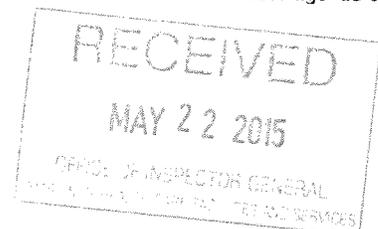
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F 226	Continued From page 21 Director of Social Services (ASSD), Dietary Director (DD), Physical Therapy Assistant (PTA), Quality of Life Director (QLD), the Assistant Director of Nursing (ADON), and two (2) of the resident's family members.  Interviews with the care plan team on 04/15/15 with the Director of Social Services at 10:25 AM, the Assistant Director of Social Services at 10:35 AM, the 200 Unit Assistant DON at 10:40 AM, Quality of Life Director at 2:30 PM, the PTA at 2:50 PM, and one of the two (2) family members present at the Care Plan meeting and interviewed on 04/20/15 and 04/21/15 by phone revealed, Resident #10 stated CNA #1 threw the resident on the bed. In addition, staff members and family members revealed during their interviews, the Administrator was not notified of the allegation because the Assistant DON stated she would take care of this; however, she did not.  Interview with the 200 Unit Assistant DON, on 04/15/15 at 10:40 AM, revealed she did not follow the abuse policy and should have. She stated she should have gone to the Administrator; however, was leaving the facility to go to another city and was in a hurry.  Additional interview with the Assistant DON, on 04/15/15 at 3:06 PM, revealed the staff had two hours to report allegations to the Administrator and DON. She stated she was unable to speak with the DON as he was in a meeting and she should have interrupted him or spoken with the Administrator. She further stated "she protected the resident by telling another nurse that the DON was in the building if she needed anything"; however, she did not tell the nurse about the allegation. Further interview revealed, per the	F 226	This education was provided to 163 of the 166 employees in all departments including administration, LPNs, RNs, CNAs, Dietary, Housekeeping, Therapy, Laundry, Activities, Social Services and Maintenance. There are 3 staff members on vacation that we will not let work until the training is obtained and posttest competencies completed. The Staff Development Coordinator will educate all new hires prior to starting department orientation. This facility does not utilize agency staff.  Monitoring:  Effective 4/17/15, all facility care plan meetings will be attended by the Administrator, Administrator in Training, DON, or one of the 2 MDS Nurses. The next scheduled care plan meeting is 4/21/15. These individuals will monitor the communication from the family and/or the resident to insure allegations of abuse are reported and acted upon per the Abuse policy.  What corrective action will be accomplished for those residents found to have been affected?  F226 DON assessed identified resident for injury on 4/15/15 with no injury noted. Resident's physician was notified on 4/15/15 by Administrator and DON. Investigation was initiated on 4/15/15 by the administrator and concluded on 4/16/15 and found to be unsubstantiated. During the investigation, the identified employee was suspended.  How will the facility identify other residents that have the potential to be affected?  All residents with BIMs of 8 or greater were interviewed by the social services team regarding abuse. All interviews (73 total) were completed by 4/17/15. As a result of this, 2 additional allegations were reported to the administrator, investigated by the facility and were unsubstantiated by the facility and OIG.	5/14/15	



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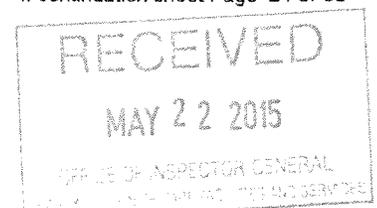
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F 226	<p>Continued From page 22</p> <p>Abuse policy, she should have reported the allegation to ensure resident safety before she left the building.</p> <p>Review of the staffing schedule revealed CNA #1 was a called in to work the second shift on 04/14/15 after the allegation was reported.</p> <p>Interview with the DON, on 04/15/15 at 8:15 AM, revealed he was not notified by the ADON of any allegation by Resident #10 stemming from the care plan meeting on 04/14/15. Another interview with the DON at 3:40 PM, revealed he was not notified until the Administrator notified him.</p> <p>Interview with the Administrator, on 04/15/15 at 5:00 PM, revealed staff should have followed the facility's policy and reported the allegation of abuse to him.</p> <p>The facility took the following actions to remove the Immediate Jeopardy as follows:</p> <ol style="list-style-type: none"> <li>1. The resident's family was aware of the allegation made by the resident as they attended the care plan meeting when the allegation was made on 04/14/15.</li> <li>2. The resident's Physician/Medical Director was notified of the allegation on 04/15/15 by the DON, with no injury identified.</li> <li>3. The DON assessed the resident for injury on 04/15/15.</li> <li>4. An investigation was initiated on 04/15/15 when the Administrator was notified. Regulating agencies were notified Office of the Inspector</li> </ol>	F 226	<p>All residents with BIMs 7 or lower had a skin assessment completed (45 total) by DON, ADONs and Transitional Care Nurse. These audits were completed by 4/17/15. No additional residents were identified.</p> <p><b>What measures will be put into place to ensure that the deficient practice will not recur?</b></p> <p>Facility has posted signage throughout the building, including break room, corridors, nurses' stations and entrances reminding staff, vendors and visitors how to immediately report suspected abuse.</p> <p>All grievances will be reviewed for allegations of abuse daily Monday through Friday by the Administrator, Administrator in Training and/or DON and daily on the weekend by the manager on duty.</p> <p>Care plans x4 weeks will be attended by the Administrator, Administrator in Training, DON or one of the 2 MDS Nurses to insure allegations of abuse are reported and acted upon per the Abuse policy. Then weekly 50% of care plans will be attended by the Administrator, Administrator in Training, DON, Transitional Care Nurse or one of the 2 MDS Nurses x 4 weeks. Then weekly, 25% of care plans will be attended by the Administrator, Administrator in Training, DON, Transitional Care Nurse or one of the 2 MDS Nurses x 4 weeks.</p>		



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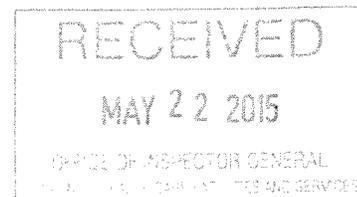
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F 226	<p>Continued From page 23</p> <p>General (OIG) and Adult Protective Services (APS). The investigation was concluded and unsubstantiated on 04/16/15 and a follow-up report was sent to OIG.</p> <p>5. The DON suspended CNA #1 on 04/15/15 at 12:18 PM.</p> <p>6. The Administrator interviewed Resident #10, on 04/15/15 at 12:15 PM.</p> <p>7. On 04/15/15, 04/16/15, and 04/17/15 Staff assigned to complete resident interviews were the Director of Social Services, Assistant Director of Social Services, and the Transitional Care Nurse/Staff Development. An Abaqis tool (a Quality Assurance tool) was used to interview seventy-three (73) residents with BIMS scores eight (8) to fifteen (15) regarding abuse and choices.</p> <p>8. On 04/15/15, 04/16/15, and 04/17/15 forty-five (45) residents with BIMS scores zero (0) to eight (8) had skin assessments completed to observe for signs of abuse, there were no signs of abuse identified. The skin assessments were completed by the Director of Nursing, Assistant Director of Nursing, and Staff Development. The Director of Social Services and Assistant Director of Social Services, Medical Records Nurse and Staff Development made forty-five (45) calls to responsible parties of residents with BIMS of eight (8) or less, contact was made with thirty (30) responsible parties who voiced no care concerns.</p> <p>9. On 04/17/15 a Resident Council Meeting was held by the Administrator to discuss abuse reporting, the facility's obligation to report, and how the facility would remedy the deficient</p>	F 226	<p><b>How the facility will monitor its performance to ensure solutions are sustained.</b></p> <p>The abuse interviews (conducted by Social services and Administrator in training) and skin assessments (conducted by DON and ADONs) will be completed on 25% weekly x 4 weeks, then 25% monthly x 3 months, then 25% quarterly thereafter. The administrator will review the results of the abuse interviews and skin assessments weekly x4 weeks, then monthly x 3 months, then quarterly thereafter. The results of the audits will be presented to the QAPI team by the Admin and DON weekly for 4 weeks, monthly x 3 months and then quarterly thereafter for review and recommendation based upon the results.</p>	



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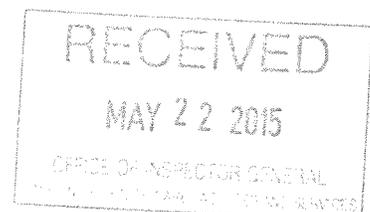
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F 226	Continued From page 24 practice.  10. On 04/15/15 a Quality Assurance Performance Improvement (QAPI) Committee meeting was held, in attendance: Medical Director, Director of Nursing, Administrator, Director of Social Services, Assistant Director of Social Services, and the Administrator in Training discussed the alleged event, reviewed the abuse Policy (no changes), and the Medical Director reviewed Resident #10's chart with no orders.  11. On 04/15/15 at 11:15 AM, immediate education was provided to the Administrator regarding the Abuse policy, by the Clinical Risk Manager. Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Physical Therapy Assistant, Assistant Director of Nursing (3), Director of Nursing, and Administrator in Training received training by the Clinical Risk Manager and the Administrator regarding the Abuse Policy.  12. On 04/15/15 at 12:45 PM, the Abuse Policy was used by the Clinical Risk Manager to educate the following: Minimum Data Assessment Nurses (2), Maintenance Director, Assistant Director of Nurses (3), Business Office manager, Admissions, Housekeeping Manager, Chaplain, Respiratory Therapist, Director of Human Resources, the Dining Services Director, Transitional Care Nurse/Staff Development, Rehabilitation Services Manager, and Medical Records.  13. Education was provided by the Administrator, Director of Nursing, Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Assistant Director of Nursing (3),	F 226			



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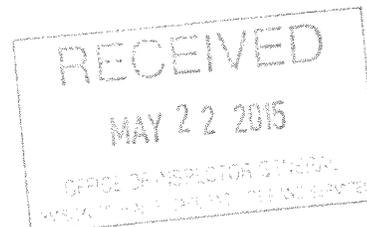
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/23/2015
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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F 226	<p>Continued From page 25</p> <p>Staff Development, Medical Director, Business Office Manager, Administrator, Housekeeping, Chaplain, Respiratory Therapist, Human Resources, Dietary Manager, Rehabilitation Manager, Medical Records, Dietitian, and RN Supervisor, on 04/15/15 thru 04/17/15 to the current staff. The current staff totaled one hundred and sixty-three (163) out of one hundred and sixty-six (166) employees on the Abuse Policy.</p> <p>14. Post education tests were provided and graded by the Administrator, Director of Nursing, Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Assistant Director of Nursing (3), Staff Development, Medical Director, Business Office Manager, Admissions, Housekeeping, Chaplain, Respiratory Therapist, Human Resources, Dietary Manager, Rehabilitation Manager, Medical Records, Dietitian, and RN Supervisor after education was completed by all staff. Staff on vacation or leave of absence would not be allowed to work until abuse education was completed.</p> <p>15. The Staff Development would educate all new hires on abuse prior to starting their department orientation.</p> <p>16. Effective 04/17/15 all Care Plan Meetings would be attended by the Administrator, Administrator in Training, Director of Nursing, or one of the two (2) MDS nurses. The next Care Plan Meeting is 04/21/15. Assigned staff will monitor feed back from residents and families.</p> <p>17. Beginning 04/21/15, once a week 25% of residents with BIMS scores eight (8) or greater</p>	F 226			



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

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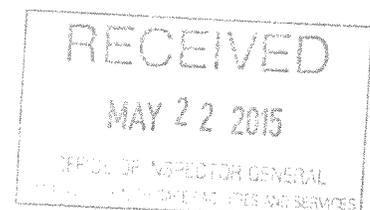
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F 226	<p>Continued From page 26</p> <p>will be interviewed by the department head or interdisciplinary team regarding abuse. Also, 25% of residents with BIMS scores of below eight (8) will have skin assessments completed by nursing management.</p> <p>18. There will be weekly QAPI meetings to review trending data with interviews, assessment and Care Plan Meetings, beginning 04/21/15.</p> <p>The State Survey Agency validated the removal of the Immediate Jeopardy on 04/23/15 prior to exit as follows:</p> <p>1. Interview with Family Member #1, on 04/20/15 at 2:40 PM, revealed he/she was present in the Care Plan meeting, heard the allegation and confirmed this knowledge with the facility.</p> <p>Interview with Family Member #2, on 04/21/15 at 8:20 AM, revealed he/she was present in the Care Plan meeting and did not hear the allegation.</p> <p>2. Interview with the Medical Director, on 04/15/15 at 1:15 PM, revealed she was notified of the abuse allegation by the Administrator and DON on 04/15/15 at 9:50 PM.</p> <p>3. Interview, on 04/15/15 at 10:02 AM, and review of the skin assessment, revealed the DON assessed Resident #10 for possible injuries related to the allegation. The assessment was documented on a CNA Skin Care Sheet. No injuries were found.</p> <p>4. Interview with the Administrator, on 04/15/15 at 1:41 PM, and review of the facility's notification to OIG and APS by fax revealed the allegation of</p>	F 226			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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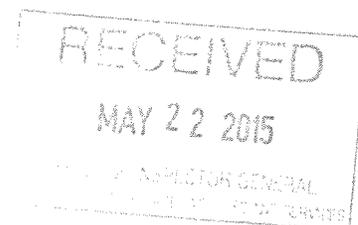
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F 226	<p>Continued From page 27</p> <p>abuse was reported and the investigation was initiated by the Administrator. On 04/16/15 at 7:32 PM a follow-up report of a completed investigation was faxed to OIG and APS.</p> <p>5. Review of the Stakeholder Suspension Form, dated 04/15/15, revealed on 04/15/15 CNA #1 was suspended per a conference call by the DON. The Stakeholder Suspension Form was witnessed by the DON, HR, and ADM.</p> <p>6. Interview with the ADM, on 04/21/15 at 1:30 PM, revealed he met with Resident #10 on 04/15/15 at 12:15 PM and he/she confirmed during the Care Plan meeting he/she stated CNA #1 threw him/her on the bed on 04/11/15.</p> <p>7. Review of seventy-three (73) interview forms revealed on 04/15/15 thru 04/17/15 Abuse interviews were completed with seventy-three (73) residents with BIMS scores eight (8) to fifteen (15).</p> <p>Interviews with two (2) unsampled residents, Unsampled Resident A on 04/21/15 at 9:38 AM, Unsampled Resident B on 04/21/15 at 9:46 AM, and on 04/21/15 at 10:15 AM with Resident #10, revealed resident abuse interviews were conducted by the Director of Social Services and the Assistant Director of Social Services.</p> <p>8. Review of the BIMS roster revealed on 04/22/15 a total of forty-five (45) of a one hundred and eighteen census (118) had BIMS scores less than eight (8). Review of the forty-five (45) skin assessment revealed all of these residents had skin assessments completed by the Assistant Director of Nursing, Staff Development, and Director of Nursing on 04/15/15 thru 04/17/15.</p>	F 226			



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

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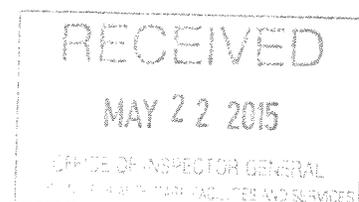
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F 226	Continued From page 28  Review of the spread sheet to document the phone calls revealed the Director of Social Services and the Assistant Director of Social Services, Medical Records Nurse and Staff Development made forty-five (45) attempts to contact responsible parties for abuse concerns. Thirty (30) of the forty-five (45) responsible parties were contacted with no voiced concerns of abuse.  Interviews, on 04/22/15 with four (4) random responsible parties for Unsampled Resident J at 1:40 PM; at 1:43 PM for Unsampled Resident K; at 1:45 PM for Unsampled Resident L, and at 1:48 PM for Unsampled Resident M, verified they were called by the facility and they voiced no concerns related to abuse.  9. Review of the Resident Council Minutes, revealed on 04/17/15 at 5:00 PM, a Special Resident Council Meeting was held by the ADM to discuss the allegation and the importance of reporting abuse and the action the facility would initiate to remedy the deficient practice.  Interview with the Administrator, on 04/22/15 at 3:08 PM, revealed during the Special Resident Council meeting he explained the deficient practice (IJ), encouraged the Council to report any suspected abuse, and explained how the deficiency would be corrected.  Interviews with Unsampled Resident C, on 04/22/15 at 2:25 PM, Unsampled Resident E, on 04/22/15 at 2:40 PM, and Unsampled Resident D, on 04/22/15 at 2:47 PM, revealed there was a Special Resident Council Meeting on 04/17/15 with the ADM to discuss the survey, abuse	F 226			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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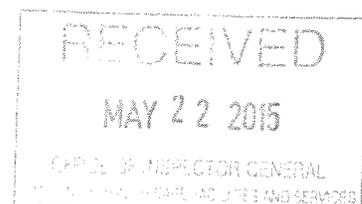
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F 226	Continued From page 29 reporting, obligations to report abuse, and how to remedy the deficient practice.  10. A QAPI meeting was held on 04/15/15 to discuss the allegation, review the Abuse Policy, and the Medical Director reviewed Resident #10's chart with no orders given.  Review of the QAPI meeting sign-in sheet revealed the following were present: Medical Director, Director of Social Services, Assistant Director of Social Services, Administrator in Training, DON, and the Administrator.  Review of the medical record for Resident #10 revealed no new orders written related to the allegation of abuse.  Interview with the ADM, on 04/22/15 at 2:25 PM, revealed in the QAPI meeting on 04/15/15, a summary of the alleged event was verbally presented to the QAPI team. The Abuse Policy, dated March 2013, was reviewed with no changes. The Medical Director reviewed the chart of Resident #10, no orders were written.  Interview with the Medical Director, on 04/22/15 at 2:32 PM, revealed she attended the QAPI meeting with review of Resident #10's medical record and medications with no new orders, and they reviewed the Abuse Policy with no changes. The ADM reviewed the allegation event with the team.  11. Review of the Abuse in-service sign-in sheet lead by the Clinical Risk Manager and the Administrator, on 04/15/15 at 11:15 AM, revealed the Quality of Life Director, Assistant Social	F 226			



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

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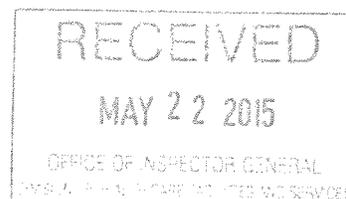
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F 226	<p>Continued From page 30</p> <p>Services Director, Director of Social Services, Physical Therapy Assistant, and 200 Unit ADON who were present at the care plan meeting at the time Resident #10 made an allegation of physical abuse were in-serviced on the abuse policy. The Administrator in Training and Director of Nursing were also educated at this meeting.</p> <p>Interview with the Administrator, on 04/21/15 at 1:12 PM, revealed he and the Corporate Director of Clinical Risk Management immediately in-serviced the Quality of Life Director, Assistant Director of Social Services, Director of Social Services, Physical Therapy Assistant, and 200 Unit Assistant Director of Nursing who were present at the care plan meeting and also the Administrator in Training and Director of Nursing.</p> <p>Interview with the Clinical Risk Manager, on 04/21/15 at 2:40 PM, revealed she in-serviced the Administrator prior to him assisting with training on 04/15/15.</p> <p>Interview with the Quality of Life Director, on 04/21/15 at 3:30 PM, revealed she was trained by the Administrator and Clinical Risk Manager and could state the reporting process.</p> <p>Interview with the Director of Social Services, on 04/21/15 at 3:34 PM, revealed she was trained by the Administrator and Clinical Risk Manager and could state the reporting process.</p> <p>Interview with the Assistant Director of Social Services, on 04/21/15 at 3:49 PM, revealed she was trained by the Administrator and Clinical Risk Manager and could stated the reporting process.</p> <p>12. Review of the Abuse in-service sign-in sheet</p>	F 226			



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

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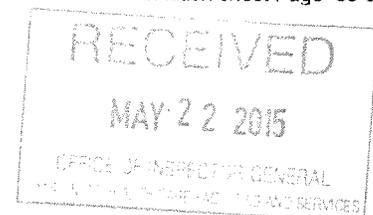
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F 226	<p>Continued From page 31</p> <p>lead by Clinical Risk Manager on 04/15/15 revealed, Staff Development, MDS nurses (#1 and #2), Maintenance Director, ADON's (100 and 300 units), Business Office Manager, Admissions, Housekeeping Manager, Chaplain, Respiratory Therapist, Director Human Resources, Dining Services Manager, Rehabilitation Services Manager, and Medical Records were present in the training.</p> <p>Interviews on 04/21/15 revealed the following stated they were educated on 04/15/15; Staff Development at 2:15 PM; Dining Service Manager at 2:25 PM; Business Office Manager at 2:30 PM; MDS #2 at 2:50 PM; Maintenance Director at 2:55 PM; Respiratory Therapist at 2:58 PM; Human Resource Director at 3:00 PM; House Keeping Supervisor at 2:15 PM; 100 Unit ADON at 3:17 PM; Rehabilitation Manager at 3:19 PM; Admissions Director at 3:21 PM; Medical Records at 3:21 PM; and, the 300 Unit ADON at 3:45 PM.</p> <p>13. On 04/15/15 thru 04/17/15 current staff were educated on the Abuse Policy. The educators were the Administrator, Director of Nursing, Assistant Director of Nurses (3), Director of Social Services, Assistant Director of Social Services, Quality of Life Director, Staff Development, MDS (#1 and #2), Maintenance Director, Business Office Director, Admissions, Housekeeping Manager, Chaplain, Respiratory Therapist, Director of Human Resources, Dining Services Manager, Rehabilitation Manager, Medical Records, Registered Nurse Supervisor, and Dietitian.</p> <p>Interviews on 04/21/15 revealed the following stated 100% of their staff was in-serviced on</p>	F 226			



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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 226	<p>Continued From page 32</p> <p>abuse: Administrator at 1:12 PM, Director of Social Services at 1:40 PM, Assistant Director of Social Services at 1:50 PM, MDS #1 at 1:55 PM, Chaplain 2:10 PM, Staff Development at 2:15 PM, Dining Services Manager at 2:25 PM, Business Office Manager at 2:30 PM, Quality of Life Director at 2:45 PM, MDS #2 at 2:50 PM, Maintenance Director at 2:55 PM, Respiratory Therapist at 2:58 PM, Human Resource Director at 3:00 PM, Director of Nursing at 3:10 PM, Housekeeping Director at 3:15 PM, 100 Unit ADON at 3:17 PM, Rehabilitation Manager at 3:19 PM, Admissions at 3:21 PM, Medical Records at 3:23 PM, 300 Unit ADON at 3:45 PM, ADON 200 unit at 3:48 PM, and, on 04/22/15 telephone interviews with the Dietitian at 9:40 AM and the Registered Nurse Supervisor at 10:00 AM.</p> <p>Interviews on 04/21/15 with PTA #1 at 1:30 PM; on 04/22/15 with LPN #7 at 10:05 AM; LPN #6 at 10:10 AM; RN #3 at 10:15 AM; CNA #11 at 10:30 AM; Dietary Aide #1 at 10:40 AM; SLP #1 at 10:45 AM; Housekeeper #3 at 10:50 AM; CNA #10 at 10:52 AM; CNA/CMT #9 at 10:55 AM; and, CNA #8 at 11:00 AM revealed they had all be trained on the Abuse policy and were able to voice their responsibility for reporting allegation of abuse to the Administrator.</p> <p>14. Review of 166 post tests on 04/21/15 revealed all 166 of the facility staff members had abuse in-services and completed the post test.</p> <p>15. Interview with Human Resources, on 04/22/15 at 3:50 PM, revealed there had been no new hires from 04/15/15 through 04/22/15.</p> <p>16. Interview with the Administrator, on 04/22/15</p>	F 226			



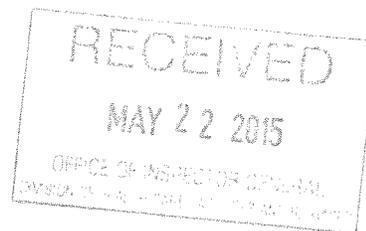
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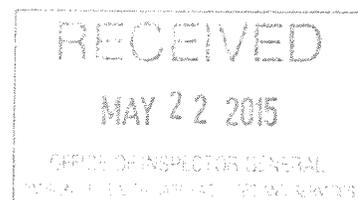
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F 226	<p>Continued From page 33</p> <p>at 3:39 PM, revealed all future Care Plan Meetings would have assigned staff Administrator, Director of Nursing, MDS (#1 and #2), or Administrator in Training at all meetings.</p> <p>Review of the Care Plan Conference Summary revealed there were three (3) Care Plan Meetings on 04/21/15. At the first meeting the DON and MDS #1 were present. MDS #1 was present at the second and third meetings.</p> <p>17. Review of the Abuse Assessment and Skin Assessments, dated 04/21/15, revealed twenty (20) abuse assessments were completed for residents with BIMS scores of eight (8) to fifteen (15) by the Administrator in Training and five (5) skin assessments were completed for residents with a BIMS scores of zero (0) to eight (8) by the 100 Unit ADON.</p> <p>Interview on 04/22/15 with Resident #19 at 9:30 AM, Unsampld Resident N at 9:25 AM, Unsampld Resident O at 9:35 AM, Unsampld Resident Q at 9:55 AM, Unsampld Resident R at 10:00 AM, Unsampld Resident #S at 10:40 AM, Unsampld Resident #T at 10:50 AM, revealed staff had completed an abuse assessments.</p> <p>Interview with the ADM, on 04/22/15 at 3:49 PM, revealed the facility would complete weekly abuse assessments for 25% of the residents with a BIMS score eight (8) to fifteen (15) and 25% skin assessment for residents with BIMS scores of zero (0) to eight (8).</p> <p>18. Review of the QAPI minutes, on 04/22/15, revealed the facility had a QAPI meeting on 04/22/15 and discussed the actions put in place to correct the deficient practice. The minutes</p>	F 226		



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

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F 226	Continued From page 34 reflected five (5) skin assessments were complete and twenty (20) abuse assessments were completed so far.  Interview with the Administrator, on 04/22/15 3:49 PM, revealed weekly QAPI meetings would be held to track and trend any abuse concerns.	F 226			



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

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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF EAST LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2529 SIX MILE LANE LOUISVILLE, KY 40220</b>		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1973, 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III (200)</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator, installed in 1984. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 04/14/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000			

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

TITLE

(X6) DATE

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.