

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

PRINTED: 11/02/2012
FORM APPROVED
OMB NO. 0938-0391

*Acceptable
POC 11/28/12*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/19/2012
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NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41008
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 226 SS-D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure written policies and procedures were implemented to protect residents from potential further abuse for two (2) of six (6) sampled residents (Residents #5 and #2).</p> <p>On 10/08/12, the staff failed to immediately report a resident to resident abuse occurrence, between Resident #3 and Resident #4, to the Director of Nursing (DON), in a timely manner; therefore, failed to prevent another abuse incident by Resident #3 who reportedly hit and kicked Resident #5. (Refer to F323)</p> <p>On 09/22/12, Resident #2 reported to State</p>	F 226	<i>See Attached</i>	<i>11/28/12</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kenneth W. [Signature]</i>	TITLE Administrator	(X8) DATE 11/12/12
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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.

Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the federal and state law.

F226

483.13(c) Develop and 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. SS:D

- Resident #2, #3, #4 and #5 were affected by the deficient practice because the staff failed to report the allegation immediately to the Administrator, Director of Nursing and Social Services Director. One of the staff involved was a new employee who was being oriented and did not report the incident immediately to her trainer; 20 minutes went by which resulted in resident #5 to become involved.
- All residents have the potential of being affected by the deficient practice due to staff not understanding clearly the policy of reporting abuse immediately and implementing/maintaining appropriate interventions.
- All of the abuse policies have been reviewed with no updates needed at this time. The Administrator, Director of Nursing, and Social Services Director will provide 100% staff re-education on the facilities Abuse Policies and Procedures, those staff members who fail to attend will be suspended until re-education is completed. Abuse Policy and Procedure and Resident Rights continue to be reviewed during general orientation. Any staff that fails to report allegations of abuse immediately will be suspended pending investigation. When an incident of abuse occurs with any resident, staff will immediately separate resident(s) to ensure resident safety and implement appropriate interventions per physician order.
- The facility is implementing "Care 2 Learn" program, this is a web based training site which will allow staff to receive training from remote sites at a computer which will make it easier for staff to comply to mandatory training requirements.
- The violation will be corrected by on or before November 28, 2012.

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F 226 Continued From page 1
Registered Nursing Assistant (SRNA) #5, someone came in his/her room and hit him/her on the head. SRNA #5, failed to report the incident of alleged abuse immediately per the facility's policy.

The findings include:

Review of the facility's Abuse, Neglect, Misreatment, and Misappropriation of Resident Property Policy, updated July 2012, revealed each resident had the right to be free from verbal, sexual, physical, and mental abuse. Under the Reporting section, the policy indicated it was the responsibility of employees to promptly report any incident or suspected incident of neglect or resident abuse. Under the Procedure section it indicated employees must report any suspected abuse or incidents of abuse to the Administrator, DON, and Social Service Director immediately.

1. Review of Resident #3's medical record revealed the resident was admitted by the facility on 10/04/12 with diagnoses which included Senile Dementia, and Generalized Anxiety. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/10/12, revealed the facility assessed the resident as severely cognitively impaired and as having behaviors which included being verbally and physically abusive.

Interview with Registered Nurse (RN) #2, on 10/19/12 at 3:00 PM, revealed Resident #3 had been upset/agitated and wanted to get out of the facility. RN #2 reported she was getting ready to do treatments, on 10/08/12 at 12:30 PM, when she heard raised voices down the hall. She went to Resident #4's room and observed Resident #3

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F 226	Continued From page 2 flailing his/her arms at Resident #4, who was standing in front of the resident and yelling for Resident #3 to leave. RN #2 reported Resident #3 struck Resident #4 in the left arm. RN #2 stepped in between the residents and yelled for help to separate the residents. Resident #3 reported Resident #4 did not hit him/her but made inappropriate comments. RN #2 informed Resident #3 that was not his/her room. Further interview revealed Resident #3 was re-directed back up the hall towards the nurses station. RN #2 stated she was being trained by LPN #1, who assisted in separating Resident #3 and Resident #4; however, interview with Licensed Practical Nurse (LPN) #1, on 10/19/12 at 2:00 PM, revealed she was training RN #2, but did not see the physical abuse event between Resident #3 and Resident #4 and RN #2 did not report the incident to her. Record review revealed no documented evidence the abuse incident was reported to the DON as per the facility's policy. Interview with SRNA #10, on 10/19/12 at 10:00 AM, who care for the resident that day, revealed she was made aware there was yelling between Resident #3 and Resident #4, but did not know of the physical contact that occurred at 12:30 PM and was told only to check on Resident #3 every so often, but stated she had not checked on the resident from 12:30 PM until 12:55 PM when SRNA #10 observed Resident #3 down the hall next to Resident #5 who was in his/her doorway. Resident #5 was upset and holding his/her left hand and reported to SRNA #10 that Resident #3 had hit and kicked him/her. Resident #3 was also upset and thought the other resident was in his/her room. SRNA #10 told Resident #3 it was	F 226			

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F 226	<p>Continued From page 3</p> <p>not his/her room and tried to re-direct Resident #3 to a different location but he/she was kicking out making it difficult to move him/her to a separate area. SRNA #10 got RN #1 who re-enforced to Resident #3 it was not his/her room and got the resident to go up to the nurses station.</p> <p>Further interview with SRNA #10 revealed when abuse events between residents occurred, the facility's process was staff to assess the situation, investigate, re-direct the residents away from the situation and staff was to check on the resident about every fifteen (15) minutes; however, she was not assigned to check on Resident #3 every fifteen (15) minutes. The SRNA further stated the intervention after the first resident to resident event, which she thought was about an hour before, was not effective because Resident #3 went to the the other resident's room (Resident #5) and was physically abusive to that resident.</p> <p>Interview with RN #1, on 10/19/12 at 11:35 AM, revealed Resident #3 was new to the facility and had only been there a couple of days and she was shocked at the resident's behavior on 10/08/12. SRNA #10 called her to Resident #5's room and reported Resident #3 had smacked Resident #5 on the hand and SRNA #10 was unable to get Resident #3 away from the room. RN #1 separated the residents and was told by Resident #5 he/she was smacked in the hand and kicked in the leg by Resident #3, upon assessment of both areas no markings were identified. Resident #3 reported he/she was not hit by Resident #5. RN #1 stated she had Resident #3 go to the nurses station and once the resident calmed down she called the resident's family who came in and stayed with the resident.</p>	F 226		

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F 226	Continued From page 4 Further interview with RN #1 revealed she was aware of the abuse event involving Resident #3 and Resident #4, at 12:30 PM, but was not aware of any interventions being put into place prior to the physical abuse event between Resident #3 and Resident #5 at 12:55 PM. Continued interview with RN #1, on 10/19/12 at 4:50 PM, revealed if there was an abuse event there should have been interventions in place to prevent any other situations to protect the residents from another physical abuse event occurring. Further interview revealed there was poor communication between staff about the events. She should have known about the first event. The event and any new interventions should have been communicated to staff. Interview with the DON, on 10/19/12 at 6:00 PM, revealed after Resident #3 bit her at 11:45 AM, staff was supposed to be monitoring the resident. At this time the resident had not been physically abusive towards other residents. The intervention to monitor the resident was not effective because the resident to resident abuse event involving Resident #3 and Resident #4 occurred about 12:30 PM. The interventions in place after the physical abuse event between Resident #3 and Resident #4 were not effective because another abuse event occurred shortly after. The resident was supposed to be removed from the area and to make sure everyone was safe. Continued interview revealed she was not made aware of the abuse incident between Resident #3 and Resident #4 until around 1:15 PM to 1:30 PM. Further interview revealed she should have been made aware of the other event between Resident #3 and Resident #4 sooner. If the event had been reported she would have	F 226			

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F 226	Continued From page 5 asked what intervention were in place. The DON's expectation was she should have been notified immediately. They did not notify her as they had been educated. 2. Record review revealed the facility re-admitted Resident #2, on 07/26/12, with diagnoses which included Senile Dementia with Delirium. Review of the Resident Abuse Investigation Report Form, dated 09/29/12, revealed the Power of Attorney (POA) reported to Registered Nurse (RN) #1, on 09/24/12 that Resident #2 told the POA that a staff nurse slapped his/her hand while in his/her room. Interview with RN #1, on 10/19/12 at 11:35 AM, revealed the POA told her, on 09/24/12, that Resident #2 reported an employee on night shift had smacked the top of his/her hand. Review of the facility's investigation revealed a written statement made by SRNA #5 which stated Resident #2 told her on Saturday (which was 09/22/12) that he/she had been slapped in the face in the middle of the night. Continued review of the written statement revealed Resident #2 said the event happened a week ago, but he/she could not see who the person was. Interview with SRNA #5, on 10/18/12 at 5:15 PM, while reviewing a Callander, revealed Resident #2 informed her on 09/22/12 that someone came into his/her room and hit him/her on the head. She stated the resident told her he/she could not see who did it. She further stated Resident #2's roommate said Resident #2 had told him/her that same story about a week ago. Interview further	F 226			

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F 226	Continued From page 8 revealed she did not report the alleged abuse incident to the DON or Administrator because she thought the allegation must have already been reported because it had occurred a week ago. Interview with the DON, on 10/19/12 at 6:00 PM, revealed the if Resident #2 told SRNA #5 on Saturday (09/22/12), that someone had slapped him/her, the SRNA should have reported the allegation to the Administer or DON upon hearing about the alleged abuse. The DON state the facillty's policy was to immediately report any allegation of abuse.	F 226			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on Interview, record review and review of the facillty's policy, it was determined the facillty failed to provide adequate supervision to each resident in order to prevent avoidable accidents for two (2) of four (4) sampled residents as evidenced by resident to resident physical abuse incidents by Resident #3 to Resident's #4 and #5. On 10/08/12 Resident #3 appeared anxious/agitated and had bitten the Director of	F 323	<i>See attached</i>	<i>11/28/12</i>	

Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the federal and state law.

**F323 483.25 (h) FREE OF ACCIDENT HAZARDS/
SUPERVISION/DEVICES; SS=D**

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

- Resident #3, #4, #5 were affected by deficient practice because the new employee failed to notify others immediately and once other staff became aware; did not implement policy to prevent another occurrence and/or provide necessary supervision. The staff involved has received teachable correction action and care plans reviewed.
- All residents have the potential to be affected by deficient practice because staff did not fully understand clearly the policy of immediate and adequate supervision. The facility did not follow abuse policy by ensuring residents safety.
- Resident #3 Care plan has been updated to reflect resident's potential for verbal and physical behaviors. Staff involved have been re-educated on how to adequately supervise. The facility will remove the aggressor from the situation and temporarily separate the resident from other residents as a therapeutic intervention to help lower the agitation. The facility will utilize all departments to provide one on one until other orders from physician.
- The Inter Disciplinary Team will review and update all residents care plans that have history or at risk for behaviors. The care plan will reflect appropriate interventions and goals.
- The violation will be completed on or before November 28, 2012.

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F 323	<p>Continued From page 7</p> <p>Nursing (DON), who tried to re-direct the resident from the elevator. After the incident, the DON had requested staff monitor the resident; however, Resident #3 was later observed in Resident #4's room slapping Resident #4's left arm at 12:30 PM and approximately a half hour later, Resident #3 was observed at the doorway of Resident #5, who reported the resident had smacked him/her on the hand and kicked him/her.</p> <p>The findings include:</p> <p>Review of the facility's Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property Policy, updated July 2012, revealed each resident had the right to be free from verbal, sexual, physical, and mental abuse. The facility had zero tolerance for abuse of its residents. Review of the Resident to Resident Abuse Procedure section revealed staff would monitor residents for aggressive/inappropriate behavior towards other residents or to the staff. Further, should a resident be observed/accused of abusing another resident, the facility would implement the following actions: a. Remove the aggressor from the situation and b. Temporarily separate the resident from other residents as a therapeutic intervention to help lower the agitation.</p> <p>Interview with the Director of Nursing (DON), on 10/19/12 at 6:00 PM, revealed the facility's abuse policy and procedure was to make sure the residents were safe, separate the residents involved in a resident to resident altercation and take them to a calm area. The facility was to ensure residents were protected. Her</p>	F 323			

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expectation would be after a resident to resident event, there should be no more events.

Review of Resident #3's medical record revealed the resident was admitted by the facility on 10/04/12 with diagnoses which included Senile Dementia, and Generalized Anxiety. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/10/12, revealed the facility assessed the resident as severely cognitively impaired and as having behaviors which included being verbally and physically abusive.

Review of Resident #3's Total Plan of Patient Care, completed on admission revealed the facility assessed the resident's mental attitude as confused, but there was no documented evidence the facility initiated a plan of care to address behaviors as the resident had exhibited no behaviors prior to admission.

Interview with the DON, on 10/19/12 at 6:00 PM, revealed she had observed Resident #3, on 10/08/12 around 11:45 AM, trying to get on the elevator and when the DON re-directed the resident got upset and bit the DON on the arm. The DON then sat with the resident attempting to calm him/her down and the family was called to come sit with the resident. The resident appeared calm and the DON told the nurses to keep an eye on resident who was by the nurses station. Review of the Nurses Notes revealed the incident was documented; however, there was no evidence the facility increase the supervision level for Resident #3.

Interview with State Registered Nurse Aide (SRNA) #12, on 10/19/12 at 11:00 AM, who was

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F 323	<p>Continued From page 9</p> <p>assigned to Resident #3 on 10/08/12, revealed Resident #3 was upset and angry earlier that morning; however, she was unaware of any special monitoring interventions put into place after the incident with the DON being bitten by the resident.</p> <p>Review of the Nurses Notes dated 10/08/12 at 12:03 PM, revealed Resident #3 was attempting to get into the supply closet requiring redirection by staff. The Notes further revealed at 12:06 PM, Resident #3 was wheel self down the hall, yelling at the nurse, attempting to pull the lap top off the top of a cart, and the resident hit the nurse when the nurse went to answer the telephone and the resident pulled the telephone from the wall. The Note further stated the resident was attempting to go out doors and state he/she would get out somehow. The family was notified.</p> <p>Interview with Registered Nurse (RN) #2, on 10/19/12 at 3:00 PM, revealed Resident #3 had been upset/agitated and wanted to get out of the facility. RN #2 reported she was getting ready to do treatments, on 10/08/12 at 12:30 PM, when she heard raised voices down the hall. She went to Resident #4's room and observed Resident #3 flailing his/her arms at Resident #4, who was standing in front of the resident and yelling for Resident #3 to leave. RN #2 reported Resident #3 struck Resident #4 in the left arm. RN #2 stepped in between the residents and yelled for help to separate the residents. Resident #3 reported Resident #4 did not hit him/her but made inappropriate comments. RN #2 informed Resident #3 that was not his/her room. Further interview revealed Resident #3 was re-directed back up the hall towards the nurses station. RN</p>	F 323			

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F 323	Continued From page 10 #2 stated she was being trained by LPN #1, who assisted in separating Resident #3 and Resident #4; however, interview with Licensed Practical Nurse (LPN) #1, on 10/19/12 at 2:00 PM, revealed she was training RN #2, but did not see the physical abuse event between Resident #3 and Resident #4 and RN #2 did not report the incident to her. Interview with SRNA #10, on 10/19/12 at 10:00 AM, who care for the resident that day, revealed she was made aware there was yelling between Resident #3 and Resident #4, but did not know of the physical contact that occurred at 12:30 PM and was told only to check on Resident #3 every so often, but stated she had not checked on the resident from 12:30 PM until 12:55 PM when SRNA #10 observed Resident #3 down the hall next to Resident #5 who was in his/her doorway. Resident #5 was upset and holding his/her left hand and reported to SRNA #10 that Resident #3 had hit and kicked him/her. Resident #3 was also upset and thought the other resident was in his/her room. SRNA #10 told Resident #3 it was not his/her room and tried to re-direct Resident #3 to a different location but he/she was kicking out making it difficult to move him/her to a separate area. SRNA #10 got RN #1 who re-enforced to Resident #3 it was not his/her room and got the resident to go up to the nurses station. Further interview with SRNA #10 revealed when abuse events between residents occurred, the facility's process was staff to assess the situation, investigate, re-direct the residents away from the situation and staff was to check on the resident about every fifteen (15) minutes; however, she was not assigned to check on Resident #3 every	F 323			

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F 323 Continued From page 11
fifteen (15) minutes. The SRNA further stated the intervention after the first resident to resident event, which she thought was about an hour before, was not effective because Resident #3 went to the the other resident's room (Resident #5) and was physically abusive to that resident.

Interview with RN #1, on 10/19/12 at 11:35 AM, revealed Resident #3 was new to the facility and had only been there a couple of days and she was shocked at the resident's behavior on 10/08/12. SRNA #10 called her to Resident #5's room and reported Resident #3 had smacked Resident #5 on the hand and SRNA #10 was unable to get Resident #3 away from the room. RN #1 separated the residents and was told by Resident #5 he/she was smacked in the hand and kicked in the leg by Resident #3, upon assessment of both areas no markings were identified. Resident #3 reported he/she was not hit by Resident #5. RN #1 stated she had Resident #3 go to the nurses station and once the resident calmed down she called the resident's family who came in and stayed with the resident. Further interview with RN #1 revealed she was aware of the abuse event involving Resident #3 and Resident #4, at 12:30 PM, but was not aware of any interventions being put into place prior to the physical abuse event between Resident #3 and Resident #5 at 12:55 PM. Continued interview with RN #1, on 10/19/12 at 4:50 PM, revealed if there was an abuse event there should have been interventions in place to prevent any other situations to protect the residents from another physical abuse event occurring. Further interview revealed there was poor communication between staff about the events. She should have known about the first

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F 323 Continued From page 12 event. The event and any new interventions should have been communicated to staff.

Interview with the DON, on 10/19/12 at 6:00 PM, revealed after Resident #3 bit her at 11:45 AM, staff was supposed to be monitoring the resident. At this time the resident had not been physically abusive towards another residents. The intervention to monitor the resident was not effective because the resident to resident abuse event involving Resident #3 and Resident #4 occurred about 12:30 PM. The interventions in place after the physical abuse event between Resident #3 and Resident #4 were not effective because another abuse event occurred shortly after. The resident was supposed to be removed from the area and to make sure everyone was safe.

F 323

F 520 483.75(o)(1) QAA
SS=D COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

F 520

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee

See attached

11/28/12

Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the federal and state law.

F520

483.75(o) Quality Assessment and Assurance

(1) A facility must maintain a quality assessment and assurance committee consisting of –

- (i) The director of nursing services;**
- (ii) A physician designated by the facility; and**
- (iii) At least 3 other members of the facility's staff.**

(2) The quality assessment and assurance committee –

- (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and**
- (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies**

(3) State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

(4) Good faith attempts by the committee to identify and correct deficiencies will not be used as a basis for sanctions.

- Resident #3, #4 and #5 were affected by deficient practice because the facility failed to maintain or implement appropriate plan of action to correct this deficient practice. The staff failed to follow abuse policy and procedures by not notifying immediately appropriate personnel i.e. Director of Nursing, Administrator and Social Service Director.
- After review of records all residents have the potential to be affected by deficient practice because staff failed to follow abuse policy and procedure by immediately reporting alleged allegations to Director of Nursing, Administrator and Social Service Director.
- The facility will make all in-services mandatory, failure of staff to attend, including PRN staff, will result in being taken off the schedule. The facility is implementing "Care 2 Learn", a web based training site which will allow staff to receive training from remote sites at a computer which will make it easier for staff to comply with mandatory training requirements.
- The Violation will be completed by on or before November 28, 2012.

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F 520 Continued From page 13
except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of the facility's Plan of Correction, and review of the facility's abuse policy, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct a previously identified quality deficiency. This was evidenced by a repeated deficiency related to the facility's staff failure to immediately report an alleged resident to resident abuse event. This failure resulted in continued noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices, F-226.

The findings include:

1. Review of the facility's Plan of Correction (PoC), with a compliance date of 10/04/12, revealed the facility's Abuse Notification Form had been updated to queue staff to follow the proper abuse protocol. These protocols include the need to immediately notify the Administrator and Director of Nursing (DON). Further review revealed new employee training was implemented to review the Abuse Policy and Procedure and then to reiterate the importance of

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F 520	<p>Continued From page 14</p> <p>Abuse Policy and Procedure. In-Service on Abuse, Abuse Notification Form and proper protocol was held on 09/27/12 for State Trained Nurse Aides/Kentucky Medicine Assistant and on 09/28/12 for Nurses. In addition, Quality Assurance checks were to be conducted on all abuse reports/investigations by the DON and Administrator to assure that all abuse complaints were following abuse policies and procedures completely.</p> <p>Review of the Inservice rosters and facility staff revealed not all nursing staff (including PRN (as needed) staff) had received inservice by the compliance date of 10/04/12. A roster provided by the DON, dated 10/19/12, revealed seventeen (17) had not received the inservice.</p> <p>Interview with the DON, on 10/19/12 at 7:30 PM, revealed inservices were to correct the deficiency cited under F 226 related to reporting abuse. They reviewed how soon staff was to notify the DON/Administrator. There was no specific time on the Abuse Notification form, but the expectation relayed to the staff was the DON/Administrator were to be notified immediately. None of the inservices were mandatory and not all employees attended the inservices. They had not inserviced seventeen (17) nursing staff and some have worked since the 10/04/12 Inservice date.</p> <p>Further interview with the DON revealed they audited abuse incidents since the 10/04/12 compliance date. The DON had audited the abuse report and felt like they had followed their policies and procedures. However, upon further review one abuse incident (10/08/12) was not</p>	F 520		
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F 520	Continued From page 15 reported immediately. The staff person who completed the report was new and was being trained. The DON stated the trainer should have taken the responsibility for completing the report. The trainer should have taken the lead and completed the notification form. 2. Review of the facility's Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property Policy, updated July 2012, revealed each resident had the right to be free from verbal, sexual, physical, and mental abuse. Under the Reporting section, the policy indicated it was the responsibility of employees, facility consultants, attending Physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse to facility management. Under the Procedure section, the policy indicated employees, facility consultants, and/or physicians must report any suspected abuse or incidents of abuse to the Administrator, DON, and Social Service Director immediately. Review of a facility's investigative reports revealed on 10/08/12 at 12:30 PM a resident to resident abuse event occurred. Resident #3 had gone into the room of Resident #4 and was observed to have struck Resident #4 on the arm. There was no documented evidence the DON was made aware of the resident to resident abuse and no documented evidence increased supervision or other interventions were implemented. Further review of the facility's investigative reports revealed on 10/08/12 at 12:55 PM, Resident #3 was involved in another resident to resident abuse event. It was reported	F 520			

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F 520 Continued From page 16
Resident #3 had hit and kicked Resident #5.

Interview with Registered Nurse (RN) #2, on 10/19/12 at 3:00 PM, revealed she was getting ready to do treatments when she heard raised voices down the hall. The RN went to Resident #4's room and observed Resident #3 flailing her arms at Resident #4 who was standing in front of the resident yelling at them to leave. RN #2 reported Resident #3 struck the other resident in the left arm. Further interview revealed another nurse came and re-directed Resident #3 back up the hall towards the nurses station. RN verified she documented the time on the Abuse Notification Form as being 12:30 PM. It was the first time she had filled out the abuse report. RN #2 stated when an abuse event occurred the policy process was to separate the residents to ensure the safety of the residents, assess the residents, do the paper work and contact the family, DON, Physician, and Administrator.

Interview with Licensed Practical Nurse (LPN) #1, on 10/19/12 at 2:00 PM, revealed she was training RN #2, but did not see the physical abuse event between Resident #3 and Resident #4. The LPN stated RN #2 reported observing Resident #3 strike Resident #4, this was reported to her after the physical abuse event between Resident #3 and Resident #5 had happened. The LPN had RN #2 complete the Abuse Notification Form and notify the MD, DON and the two family members.

Interview with RN #1, on 10/19/12 at 11:35 AM, revealed the RN was called by an aide to Resident #5's room and the aide reported Resident #3 had smacked Resident #5 on the

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F 520	Continued From page 17 hand. The RN separated the residents and was told by Resident #5 he/she was smacked in the hand and kicked in the leg by Resident #3, but no markings were observed. Interview with the DON, on 10/19/12 at 6:00 PM, revealed she was not made aware of the abuse incident between Resident #3 and Resident #4 (documented time 12:30 PM) until 1:15 PM to 1:30 PM. Further interview with the DON revealed she was made aware of the abuse event between Resident #3 and Resident #5 first (documented time 12:55 PM) and should have been made aware of the other event between Resident #3 and Resident #4 earlier. If it had been reported to the DON sooner she would have asked what intervention were in place. The DON's expectation was she should have been notified sooner and staff did not notify her as they had been educated.	F 520			