

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

PRINTED: 06/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 05/13/2015
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217		
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F 520	Continued From page 179 review that resident care plans were up to date, make any needed changes, and interventions were implemented. 18. Interview, on 04/09/15 at 3:31 PM, with the Compliance Auditor revealed she would audit the Program of Care meetings three (3) times a week for four (4) weeks, three (3) times a month for one (1) quarter, then quarterly and give the results to the DON for the QA Committee. 19. Interview with the Compliance Auditor, on 04/09/15 at 3:31 PM, revealed she would conduct ten (10) chart audits each month for three (3) months, then quarterly to ensure care plans were updated and interventions performed, with discrepancies corrected by the UM. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed the Compliance Auditor would complete ten (10) chart audits and ensure the residents' care plans interventions were implemented; the UM would correct any issues immediately. She stated results would be taken to the QA Committee. Review of the Care Plan Monitoring Tool, dated April 2015, revealed it included review of the resident care plan, if the care plan had been updated, observations, concerns, if the care plan was followed, and Assistant UM or UM aware of result. 20. Interview with the Nutrition Services Director, on 04/09/15 at 1:58 PM, the Social Services Director, on 04/09/15 at 2:11 PM, the Activities Director, on 04/09/15 at 2:24 PM, the HR Director, on 04/09/15 at 2:43 PM, the Compliance Auditor, on 04/09/15 at 3:31 PM, the QA Director, on 04/09/15 at 3:45 PM, the Rehab Manager, on 04/09/15 at 3:55 PM, the Medical Director, on	F 520			

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F 520	Continued From page 180 04/09/15 at 4:07 PM, the Treatment Nurse, on 04/09/15 at 4:25 PM, the Clinical DON, on 04/09/15 at 4:48 PM, the Administrative DON, on 04/09/15 at 5:03 PM, and the Administrator, on 04/09/15 at 5:14 PM, revealed they attended QA meetings, with three (3) held, and discussed the Immediate Jeopardy (IJ), corrective actions, care plans, new checklists, and training. Review of sign in sheets that included review of the IJ and corrective actions revealed QA meetings were held on 04/03/15, 04/06/15, and 04/08/15. An abbreviated survey conducted 04/28/15 investigating KY 23169 and KY 23245 determined the facility failed to implement the corrective actions of the AOC dated 04/09/15. Review of the acceptable AOC, dated 04/09/15, revealed the abuse allegation checklist and abuse allegation log would be audited by the Compliance Auditor and the results would be brought to the QA committee. Review of the newly developed checklist to be utilized by the facility to ensure abuse investigations were completed, (which was an intervention on the AOC) revealed no date when it was completed and only checks on the forms without any additional information provided. Interview with the Compliance Auditor, on 04/30/15 at 1:15 PM, revealed when she reviewed the newly developed checklist she only looked for the check marks and did not review the content of the investigation. In addition, she stated the audits of the abuse investigation checklist were not taken to the Quality Assurance (QA) meeting on 04/27/15. Interview with the Administrator, on 04/30/15 at 3:45 PM, validated	F 520			

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F 520	<p>Continued From page 181</p> <p>the audits of the checklist and the abuse logs were not discussed at the 04/27/15 QA meeting.</p> <p>Immediate Jeopardy was determined not to be removed on 04/09/15 as alleged. The facility was notified of this finding on 04/30/15. The facility took the following actions to remove the Immediate Jeopardy on 05/06/15 as follows:</p> <ol style="list-style-type: none"> 1. The Clinical DON made notification on 04/20/15 of the allegation (KY 23169) to Resident #36's family, physician, OIG and DCBS. The Administrative DON made notification of the allegation of abuse (KY23245) to Resident #37's family and Physician on 04/27/15. Notification to the OIG and DCBS was made on 04/28/15. 2. On 04/21/15, a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor with no injuries consistent with abuse noted. Fifty-six (56) skin assessments were completed on non-interviewable residents by Unit Managers, Assistant Managers, and Staff Development Nurse as of 05/04/15. No issues were found. 3. 05/04/15, one hundred thirty (130) residents were interviewed by Social Services, and the RAI Coordinators to ensure there were no unresolved or uninvestigated allegations of abuse. No issues were identified. 4. The abuse allegation checklist was revised on 04/28/15 by the Clinical DON to reflect name, date, and time of actions, with a space for narrative documentation to record all actions taken during the abuse investigation. 5. On 05/01/15, the facility obtained the services 	F 520		
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F 520	Continued From page 182 of a consultant company to provide assistance with training, policy revision, QA and ongoing oversight and consultation. These consultant employees included Nurses, therapists, and Administrators. The facility's Administrative DONs, Human Resources Director, and Assistant Director of Nurses met with the consultants and revised the abuse policy to reflect procedures for immediate protection of residents by removal of the alleged perpetrator from patient care and reporting immediately allegations of any abuse to the state agencies. All staff would receive training on the new Abuse policy revisions and no staff would work past 05/05/15 without receiving the training. This would include agency staff. 6. On 05/05/15, education was provided by the contracted consultant on requirements for abuse allegation reporting and investigation with competency. No staff would be allowed to work past 05/05/15 without receiving the training. This would include agency staff. As of 05/05/15, two hundred ninety-seven (297) employees had been trained. 7. On 05/04/15, the facility implemented a new Nurses' Abuse Allegation Investigation Protocol. The protocol was a step by step reference for nurses and House Supervisors to be used when a resident alleged abuse. The protocol was posted in visible locations on all nursing units and included in all staff education. (Attachment B) 8. On 05/04/15, a QA meeting was held to review the alleged deficient practice and plans of actions established to correct the practices. The consultant observed the QA meeting. Members present included the Administrator, Consultant, Social Services, Medical Director, DONs and	F 520			

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F 520	Continued From page 183 other Department Directors. The Administrator established a weekly QA meeting that included review of the deficiencies cited.	F 520			
	<p>9. On 05/04/15, the Elder Justice Act reporting notification requirements was added to the admission packet. The revised Abuse policy and Elder Justice Act information was placed in a binder at the receptionist desk.</p> <p>10. On 05/05/15, five (5) random staff and resident interviews would be conducted weekly by Social Services and Nursing Administration to ensure there were no unresolved/investigated abuse allegations and staff understanding of reporting requirements.</p> <p>11. On 05/04/15, the contracted consultant educated the Administrator and made observations at the facility to ensure the Administrator was administering the facility in accordance with professional standards and per his job description included ensuring a system was in place to protect residents from abuse and neglect.</p> <p>12. Beginning 05/01/15, a consultant would conduct weekly visits for four weeks then monthly visits to ensure the Administrator followed professional standards and job description ensuring systems remained in place for reporting and investigation of allegations of abuse and neglect per established plan of correction. The Administrator established weekly administrative consultative visits with the consultants.</p> <p>13. The contract consultant re-educated the</p>				

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F 520	Continued From page 184 Administrator, on 05/04/15, on the requirements of a functional QA process to include delegation of action items for identified concerns including oversight of entire AOC and implementation of systems and follow-up to ensure corrections were made and reviewed with the Interdisciplinary Team (IDT). 14. Beginning 05/04/15 the Human Resources Director would update the Administrator daily of the status of staff training on abuse. 15. On 05/05/15, the Administrator amended the agenda for the daily quality meeting with the IDT, to address deficiencies cited. This included reviewing audits, education, and ongoing monitoring to determined effectiveness of current actions. 16. Weekly QA meetings that began on 05/04/15, was held to review identified concerns regarding any issues with the Plan of Correction and follow-up to ensure corrections were sustained. The meeting would consist of at a minimum the Administrator, Director of Nursing, Social Services, Assistant Director of Nursing, and other Department Directors. The contract consultant would observe the QA process monthly, including audit tools (attachment E) for at least three (3) months to ensure Quality Assurance Performance Improvement Committee was functional and meeting the identified needs of the facility. The QA committee would consist of the Administrator, DONs, ADON, Social Services, and the Medical Director attending at least quarterly. When the Medical Director was present, they would review a sample of residents' abuse allegations for	F 520			

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F 520	Continued From page 185 effectiveness in the revised processes. The QA meeting would review audits (and take action if needed) related to the deficiencies. Theses audits would include resident interviews and skin audits conducted on 05/04/15 and abuse audits which began on 04/08/15 and are ongoing. The reports would be presented by the Compliance Auditor. The State Survey Agency validated the removal of Immediate Jeopardy on 05/13/15 prior to exit as follows: 1. Review of the clinical record and facility investigation validated the Clinical DON notified Resident #36's family, physician, OIG, and DCBS on 04/20/15. Review of the fax verification revealed the OIG was notified on 04/20/15 at 4:09 PM. Review of the clinical record and facility investigation revealed the Administrative DON notified Resident #37's family and physician on 04/27/15. Review of the faxed verification sheet revealed notification to the OIG on 04/28/15 at 3:11 PM. Review of the Department of Community Based Services (DCBS) intake summary revealed the notification was received on 04/29/15. Interview with the Administrative DON, on 04/29/15 at 2:24 PM, revealed the facility's fax machine was broken on Monday, April 27, 2015 and she failed to provide notification via telephone. 2. Review of facility's investigation revealed a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor on 04/21/15, with no injuries consistent with abuse.	F 520			

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F 520	Continued From page 186 Review of the skin assessments conducted by the Unit Managers, Assistant Managers, and Staff Development Nurse through 05/04/15, revealed fifty-three (53) skin assessments were conducted for residents with a BIMS score less than eight (8).	F 520		
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	<p>3. Review of the resident interview forms revealed Social Services, and the RAI Coordinators conducted one hundred thirty-three (133) resident interviews by 05/04/15. No resident alleged abuse. The interview form included a questionnaire for staff to determine if the resident had any mood or behavioral changes. None was noted.</p> <p>4. Interview with the Clinical DON, on 05/13/15 at 4:20 PM, revealed the abuse checklist was revised to give more details to ensure the investigation was conducted and timely. In addition, the Compliance Auditor would be able to determine if the investigation was completed timely and according to the facility's Abuse policy.</p> <p>Review of the checklist for the abuse investigation for Residents #37, 38, 39, 40, 41, 42, and #43 revealed the abuse checklist was completed with details of notification (including the state agencies), protection of the resident, resident and staff interviews, meeting with DONs and Administrator, and when copy of the checklist was sent to the QA committee. Residents #38, 39, 40, 41, 42, and 43 was completed after the facility was notified of the Immediate Jeopardy.</p> <p>5. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff</p>			
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F 520	<p>Continued From page 187</p> <p>and assistance with development of the AOC, and QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15. He stated the Abuse policy was revised on 05/04/15 with input from the consultant services.</p> <p>Review on 05/13/15, of the revised Abuse policy, revealed language changes in how the residents would be protected included the employee suspected of abuse would be removed from the unit and patient care immediately. The House Supervisor or Nursing Administration would assure the employee clocked out and left the facility. Employees who witnessed potential abuse are instructed to immediately intervene to protect the resident, the alleged perpetrator should not be left alone with the resident. All employees were required to immediately report any observations, suspicion, or information of suspected or actual abuse, neglect, or misappropriation of property to the House Supervisor. House Supervisor or Nursing Administration would report all allegations of abuse or neglect to DCBS, Police, and OIG immediately.</p> <p>Four (4) abuse investigations were reviewed on 05/13/15 for Residents #40, 41, 42 and #43 and validated the facility used the abuse investigation checklist and the QA investigation tool. Based on residents' interviews, record review, and review of the facility's investigation, no problems were found with these abuse investigations.</p> <p>Review of the training records revealed all working staff had been trained on the new abuse policy.</p>	F 520			

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F 520	Continued From page 188 Observations on 05/13/15 of the second, third, fourth, fifth, and seventh floors revealed the revised Abuse policy of 05/04/15 had been placed in the policy binder at each nurse's station and the binder was easily assessable to all staff for review. 6. Review of the training records and the staff roster validated all working staff had been trained on the revised Abuse policy by 05/05/15. The training was provided by the consultant via classroom on 05/04/15 and through a thirty (30) minute video through 05/05/15. A pre and post test was required. Interviews conducted on 05/13/15 with CNA #25, at 3:05 PM, CNA #2 at 2:30 PM, CNA #27 at 2:35 PM, CNA #28 at 3:30 PM, CNA #30 at 2:42 PM, CNA #32 at 2:44 PM, CNA#31 at 2:47 PM, CNA student #1, at 3:43 PM, and CNA student #2 at 3:50 PM validated they had received recent training on abuse. The staff could identify abuse, how to protect the resident and when and whom to report abuse. Interview on 05/13/15, with the Unit Manager for the Fourth floor at 2:49 PM, Third floor at 2:50 PM, Second floor at 3:20 PM, and Seventh floor at 3:43 PM revealed the managers received abuse training with the revised Abuse policy. The managers knew the location of the Abuse policy and the new Nurse' Abuse Allegation Protocol was posted at each nurses' station. In addition, interview with LPN #5 at 3:07 PM, LPN #11 at 3:15 PM, LPN #12 at 2:40 PM, and LPN #1 at 3:09 PM revealed they had received abuse training with a pre and post test. Interview with the Unit Sectary for the Second	F 520			

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F 490	<p>Continued From page 189</p> <p>3. Review of the resident interview forms revealed Social Services, and the RAI Coordinators conducted one hundred thirty-three (133) resident interviews by 05/04/15. No resident alleged abuse. The interview form included a questionnaire for staff to determine if the resident had any mood or behavioral changes. None was noted.</p> <p>4. Interview with the Clinical DON, on 05/13/15 at 4:20 PM, revealed the abuse checklist was revised to give more details to ensure the investigation was conducted and timely. In addition, the Compliance Auditor would be able to determine if the investigation was completed timely and according to the facility's Abuse policy.</p> <p>Review of the checklist for the abuse investigation for Residents #37, 38, 39, 40, 41, 42, and #43 revealed the abuse checklist was completed with details of notification (including the state agencies), protection of the resident, resident and staff interviews, meeting with DONs and Administrator, and when copy of the checklist was sent to the QA committee. Residents #38, 39, 40, 41, 42, and 43 was completed after the facility was notified of the Immediate Jeopardy.</p> <p>5. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff and assistance with development of the AOC, and QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15. He stated the Abuse policy was revised on 05/04/15 with input from the consultant services.</p>	F 490			

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F 490	Continued From page 190 Review on 05/13/15, of the revised Abuse policy, revealed language changes in how the residents would be protected included the employee suspected of abuse would be removed from the unit and patient care immediately. The House Supervisor or Nursing Administration would assure the employee clocked out and left the facility. Employees who witnessed potential abuse are instructed to immediately intervene to protect the resident, the alleged perpetrator should not be left alone with the resident. All employees were required to immediately report any observations, suspicion, or information of suspected or actual abuse, neglect, or misappropriation of property to the House Supervisor. House Supervisor or Nursing Administration would report all allegations of abuse or neglect to DCBS, Police, and OIG immediately. Four (4) abuse investigations were reviewed on 05/13/15 for Residents #40, 41, 42 and #43 and validated the facility used the abuse investigation checklist and the QA investigation tool. Based on residents' interviews, record review, and review of the facility's investigation, no problems were found with these abuse investigations. Review of the training records revealed all working staff had been trained on the new abuse policy. Observations on 05/13/15 of the second, third, fourth, fifth, and seventh floors revealed the revised Abuse policy of 05/04/15 had been placed in the policy binder at each nurse's station and the binder was easily assessable to all staff for review.	F 490			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2015	
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217		
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F 490	<p>Continued From page 191</p> <p>6. Review of the training records and the staff roster validated all working staff had been trained on the revised Abuse policy by 05/05/15. The training was provided by the consultant via classroom on 05/04/15 and through a thirty (30) minute video through 05/05/15. A pre and post test was required.</p> <p>Interviews conducted on 05/13/15 with CNA #25, at 3:05 PM, CNA #2 at 2:30 PM, CNA #27 at 2:35 PM, CNA #28 at 3:30 PM, CNA #30 at 2:42 PM, CNA #32 at 2:44 PM, CNA#31 at 2:47 PM, CNA student #1, at 3:43 PM, and CNA student #2 at 3:50 PM validated they had received recent training on abuse. The staff could identify abuse, how to protect the resident and when and whom to report abuse.</p> <p>Interview on 05/13/15, with the Unit Manager for the Fourth floor at 2:49 PM, Third floor at 2:50 PM, Second floor at 3:20 PM, and Seventh floor at 3:43 PM revealed the managers received abuse training with the revised Abuse policy. The managers knew the location of the Abuse policy and the new Nurse' Abuse Allegation Protocol was posted at each nurses' station. In addition, interview with LPN #5 at 3:07 PM, LPN #11 at 3:15 PM, LPN #12 at 2:40 PM, and LPN #1 at 3:09 PM revealed they had received abuse training with a pre and post test.</p> <p>Interview with the Unit Sectary for the Second floor, at 3:40 PM, and a Central Supply person at 3:44 PM revealed they received training on abuse and knew when and whom to report the abuse.</p> <p>7. Observation of the Fourth floor, on 05/13/15 at 2:49 PM, Third floor at 2:50 PM, Second floor at</p>	F 490		

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F 490	<p>Continued From page 192</p> <p>3:20 PM, fifth floor at 3:35 PM, and Seventh floor at 3:43 PM revealed the Nurses' Abuse Allegation Investigation Protocol was posted at the nurses' station. Interview on 05/13/15, with the UM for the Fourth floor at 2:49 PM, Third floor at 2:50 PM, Second floor at 3:20 PM, and Seventh floor at 3:43 PM, revealed the managers received training on the new Nurses' Abuse Allegation Investigative Protocol tool and understood how to follow.</p> <p>8. On 5/13/15 at 5:05 PM, a review of the sign in sheet for QA meetings revealed a QA was held on 05/04/15 with the Consultant present. Review of the QA agenda revealed the deficiencies and plan of actions were discussed.</p> <p>Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed the QA committee reviewed the Abuse policy and survey issues with plan of actions. See attachment F. The Administrator stated he would have weekly QA meetings to review deficiencies cited. Review revealed the facility held another QA meeting on 05/11/15 that included the Medical Director. Review of the May 11, 2015 QA meeting agenda revealed the QA committee would review the AOC, action plans and audits</p> <p>9. Observation upon entrance of the facility, on 05/13/15 at 12:45 PM, revealed a binder at the receptionist desk that included the revised Abuse Policy and Elder Justice Act information. The binder was available for the public to view. Review of the admission packet revealed the information on the Elder Justice Act was included.</p> <p>10. On 05/13/15 at 4:45 PM, a review of the five random staff and resident interviews were</p>	F 490		

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F 490	Continued From page 193 validated completed on 05/05/15. No concerns was voiced. Interview with Social Worker #1, on 05/13/15 at 4:50 PM, revealed she had received training on the revised Abuse policy. She stated she conducted some of the resident and staff interviews. She received no concerns. She felt the new system was more effective because everyone was more aware of abuse and knows how to protect the residents and when to report the abuse. 11. Review of attachment F and the copy of the Administration training validated the Administrator was re-educated by the consultant on 05/04/15. See attachment F and copy of training. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff; assistance with development of the AOC; and, QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15 for administrative visits. The Administrator stated he had received training on how to conduct a functional QA meeting to identify concerns and provide oversight of the AOC and implementation of systems. He stated he meets with the IDT team daily on each floor. He stated the Human Resources Director informed him each morning how many employees had been trained and how many need the training.	F 490			

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F 490	Continued From page 194 Interview with the Human Resources Director, on 05/13/15 at 4:37 PM, revealed all staff working had been trained. 12. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant's services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff and assistance with development of the AOC, and QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15 for administrative visits. 13. Interview with the Administrator, on 05/13/15 at 6:20 PM revealed he had received training on how to conduct a functional QA meeting to identify concerns and provide oversight of the AOC and implementation of systems. He stated he meets with the IDT team daily on each floor. He stated the Human Resources Director informs him each morning how many employees have been trained and how many need the training. 14. Interview with the Human Resources Director, on 05/13/15 at 4:37 PM, revealed she reported daily to the Administrator how many staff had been trained. She stated all staff had been trained by 05/05/15 with exception of those on medical leave. 15. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed he changed the agenda for the daily meetings with the IDT team to include the UM on each floor. They discussed the deficiencies cited and plan of actions. This would include any audits, monitoring to ensure actions plans were implemented and compliance was achieved. In addition, they discuss problems	F 490			

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F 490	Continued From page 195 specific to that floor would be discussed. 16. On 5/13/15 at 5:05 PM, a review of the sign in sheet for QA meetings revealed a QA was held on 05/04/15 with the Consultant present. Review of the QA agenda revealed the deficiencies and plan of actions were discussed. Those in attendance included the Administrator, DONs, Social Services, ADON, Medical Director and other Department Directors. Attachment F validated the Consultant was present during the QA meeting. Review of the May 11, 2015 QA meeting agenda revealed resident interviews and skin audits conducted on 05/04/15 and abuse audits which began on 04/08/15 were reviewed. The reports would be presented by the Compliance Auditor. Interview with the Compliance Auditor, on 05/13/15 at 5:30 PM, revealed she received training on the revised Abuse policy. She stated when she reviewed the abuse investigation checklist and the abuse log she was now looking at the entire abuse investigation to ensure everything was completed according to the checklist. At the QA meetings she reported to the committee how many abuse investigations were completed and her findings on the audits. She still checked the abuse log to ensure two people had reviewed the abuse investigation.	F 490			
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520	F520 1. On 4/20/15, the Clinical DON notified Resident #36's family, physician, OIG, and DCBS of the allegation.		

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F 520	<p>Continued From page 196</p> <p>nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>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.</p> <p>A 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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy and Acceptable Allegation of Compliance (AOC) dated 04/09/15, it was determined the facility failed to maintain a Quality Assurance (QA) program implemented and monitored the plans of actions as stated the Allegation of Compliance to correct quality deficiencies as evidenced by the facility's failure to ensure the Abuse Policy was implemented to protect residents from abuse for two (2) of forty-three (43) sampled residents (Resident #36 and #37). (Refer to F225, F226 and F490)</p> <p>Immediate Jeopardy (IJ) was identified on</p>	F 520	<p>The employee (CNA #22) involved in this allegation was placed on administrative leave on 4/19/15. The Unit Manager performed a skin assessment for Resident #36 on 4/20/15 and no injuries consistent with abuse were noted. The Clinical DON interviewed Resident #36 on 4/20/15 and Resident #36 expressed no fear or anxiety.</p> <p>The Administrative DON notified Resident #37's family and physician of the allegation of abuse on 4/27/15 and OIG and DCBS on 4/28/15. The employee (ORT #1) involved in this allegation was placed on administrative leave on 4/27/15. The ADON and Administrative DON interviewed Resident #37 on 4/27/15 and the resident denied fear and expressed no anxiety. The House Supervisor immediately (4/26/15) re-educated CNA #24 on the facility policy of reporting alleged abuse immediately.</p> <p>2. All residents have the potential to be affected. Skin assessments were</p>		

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F 520	Continued From page 197 04/03/15 and was determined to exist on 04/01/15 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) at a Scope and Severity of a "J"; and, at 42 CFR 483.20 Resident Assessment (F282) at a Scope and Severity of a "J". The facility's AOC, dated 04/09/15, alleged the IJ was removed on 04/09/15. However, during an abbreviated survey initiated on 04/28/15 (investigating complaints KY23169 and KY23245) it was determined the IJ at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) had not been removed as alleged, on 04/09/15. Per the facility's AOC, when an allegation of abuse was reported, the Administrator/Nursing Administrator would be notified; the alleged perpetrator would be placed on Administrative leave; and, the State Agencies would be notified not to exceed twenty-four (24) hours if no injury occurred. Further review of the revealed the Compliance Auditor or the Quality Assurance (QA) Director would audit weekly the revised abuse allegation logs and new abuse allegation checklist (tools developed to assist with the facility's investigations) and the results of the audits would be brought to the QA committee. However, interview with the Compliance Auditor, on 04/30/15 at 1:15 PM, revealed she only audited the checklist forms to ensure the check marks were made. She did not review any abuse investigation to ensure they were completed, or that they followed the facility's abuse policy. The audits conducted were not taken to the 04/27/15 QA meeting as stated in the AOC. Interview and record review determined the facility failed to implement these components of the AOC after	F 520	conducted by the Unit Managers, Assistant Managers and Staff Development Nurse on 5/4/15, for residents with a BIMS score less than eight (53 residents) and no concerns were noted. Social Services and the RAI Coordinators conducted one hundred thirty-three (133) resident interviews by 5/4/15. No resident alleged abuse. The interview form included a questionnaire for staff to determine if the resident had any mood or behavioral changes. None was noted. 3. The facility does have a policy regarding the Quality Assurance Program. The Administrator was unaware of the request for this policy. The Administrator obtained consultant services on 5/1/15. On 5/4/15, the consultant educated the Administrator and made observations at the facility to ensure the Administrator was administering the facility in accordance with professional standards and per his job description, including ensuring a system was in place to protect residents from abuse and neglect. The consultant also re-		

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F 520	<p>Continued From page 198 the facility self-reported two (2) abuse allegations.</p> <p>On 04/19/15, ten (10) days after the facility had alleged the removal of IJ, Resident #36 alleged Certified Nurse Aide (CNA) #22 was mean and rude and threw the bed covers over the resident's head. CNA #22 was allowed to care for other residents after the abuse allegation was received. The facility did not reported the allegation to the SSA until 4:09 PM on 04/20/15, greater than twenty-four (24) hours after the incident occurred.</p> <p>On 04/26/15, seventeen (17) days after the facility had alleged the removal of IJ, CNA #24 failed to follow the facility's abuse policy for reporting incidents of abuse immediately to the nurse. CNA #24 alleged he saw Outreach Technician (ORT) Restorative Aide #1 kiss Resident #37 on the lips. However, he did not report what he had witnessed until hours later after the alleged perpetrator had left for the day. The ORT Restorative Aide #1 had provided care to approximately forty (40) other residents before the end of his shift.</p> <p>In addition, the facility failed to report the abuse allegation to the State Survey Agency until two (2) days after the alleged abuse occurred.</p> <p>The facility's failure to have an effective system in place to ensure the QA committee functioned to identify quality deficiencies, develop plans of action, and implement the plans of action has caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 04/01/15.</p> <p>The facility provided a new acceptable (AOC) on 05/07/15 which alleged removal of the Immediate</p>	F 520	<p>educated the Administrator on 5/4/15 on the requirements of a functional QA process.</p> <p>The facility's Administrator, DONs, Human Resources Director and Assistant DON met with the consultants on 5/1/15 and revised the abuse policy to reflect procedures for immediate protection of residents by removal of the person involved in the alleged abuse from patient care and reporting immediately allegations of any abuse to the state agencies. The revised policy is in place at each nurses station and easily accessible to all staff for viewing. The consultants conducted abuse training that included the Nurse Abuse Allegation Protocol, developed with the assistance of the consultant staff, for all working staff by 5/5/15. The training emphasized the protection of the resident and immediate removal of the person involved in the allegation. No staff is allowed to work (i.e., any on LOA and/or agency) without receiving this training. The Nurse Abuse Allegation Protocol is posted at each nurses' station.</p>		

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F 520	<p>Continued From page 199</p> <p>Jeopardy on 05/06/15. The State Survey Agency verified Immediate Jeopardy was removed as alleged prior to exit on 05/13/15. The Scope and Severity was lowered to a "D" while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding a Quality Assurance Program.</p> <p>Review of the facility's policy regarding Abuse Prevention, Intervention and Data Collection, revised April 2015, revealed the facility would protect residents from abuse by removing any employee who was suspected of abuse immediately and place on administrative leave during the investigation. The policy stated all employees were required to report immediately any observations, suspicions or information of suspected abuse to the nursing supervisor. After consulting with the Administrator, the supervisor would immediately report the concern to the State Agencies.</p> <p>The Compliance Auditor audited the checklist forms to ensure only the check marks were made. She did not review any abuse investigation to ensure they were completed, or that they followed the facility's abuse policy. The audits conducted were not taken to the 04/27/15 QA meeting as stated in the AOC.</p> <p>Review of the AOC, dated 04/09/15, revealed the abuse allegation checklist and abuse allegation log would be audited by the Compliance Auditor or Quality Assurance Director weekly times four</p>	F 520	<p>The Administrator routinely participates in the daily quality meeting, Monday through Friday. He amended the agenda to address status related to maintaining corrections per stated plan of correction and details of any allegations of abuse. Non-immediate issues from the weekend are brought to the meeting on Monday morning. The Administrator reviews the investigations of abuse to ensure that all proper steps are followed. The Clinical Director of Nursing revised the abuse checklist on 4/28/15 to give more details to ensure the investigations are conducted and timely and according to the facility's abuse policy. The Compliance Auditor was trained on the revisions on 4/28/15 by the Clinical Director of Nursing. The Compliance Auditor now looks at the entire abuse investigation to ensure everything is complete according to the checklist.</p> <p>4. A consultant began on 5/1/15 conducting weekly administrative consultative visits. These are continuing for 4 weeks then monthly</p>	

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F 520	Continued From page 200 (4) weeks, then monthly, then quarterly. Results of the audits would be brought to the QA Committee. Review of the QA Sign-in Sheets revealed a QA meeting was held on 04/27/15. Interview with the Compliance Auditor, on 04/30/15 at 1:15 PM, revealed she only audited to ensure the checklist was completed. She stated she only looked to ensure each area was checked; however, she did not go back and see if the investigation had been completed. She stated she was just checking for the "check" marks. Further interview revealed she conducted the audits on the abuse investigation log in the same manner. She was only looking to see if there were two (2) signatures present on the abuse log . She did not check for content. She stated she took the audits to the Quality Assurance (QA) meeting conducted on 04/27/15, but they were not discussed, per the AOC the audits were to be discussed in QA. She revealed this was a quarterly QA meeting and only issues from January, February, and March were discussed. The QA Committee decided to review the audits in the July QA meeting. Further interview revealed she had not identified an problems, as she was only looking for the check marks. Interview with the Administrator, on 04/30/15 at 3:45 PM, revealed he provided oversight over the Director of Nurses (DONs), who conducted the abuse investigations. He stated the abuse investigations were discussed and it was an ongoing process. He said he thought the checklists were working. When he saw the checks he assumed the two (2) DONs had reviewed it, as the both have to sign off on the abuse log that the investigation was complete. He	F 520	for 3 months to ensure the Administrator is following professional standards and job description to ensure systems remain in place for reporting and investigation of allegations of abuse and neglect per facility policy. The Administrator established a weekly QA meeting, beginning 5/4/15, to review identified concerns regarding any issues with the Plan of Correction and follow- up to ensure corrections are sustained with the continued frequency of the meetings to be determined by the QA Committee. The meetings consist of the Administrator, Director of Nursing, Social Services, Assistant Director of Nursing, other Department Directors and Medical Director who attends at least quarterly. When the Medical Director is present, he/she will review a sample of resident's abuse allegations for effectiveness of the revised processes.	
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F 520	<p>Continued From page 201</p> <p>stated the Compliance Auditor's responsibility was to ensure each step was done on the checklist, not just check for marks. He stated he assumed that all steps had been completed. He was unaware residents were not protected during an abuse investigation and allegations were not reported according to facility policy. The Administrator stated monitoring and audits were tools used to ensure the AOC was implemented. He stated he had questioned the Compliance Auditor about the audits, but they only spoke of ensuring they were done, not of their content. No issues with the audits had been reported to him and he was told they were being implemented.</p> <p>Continued interview with the Administrator revealed the QA conducted on 04/27/15 was a quarterly QA where the committee discussed issues from January, February, and March 2015. Per interview, the committee did not talk about or review the AOC and the DONs did not discuss any abuse investigations during this meeting. In addition, he stated the Compliance Auditor did not discuss the results of the audits conducted and there was limited talk about deficiencies and corrective actions. He said there needed to be closer monitoring.</p> <p>The State Survey Agency validated the removal of Immediate Jeopardy on 04/09/15 prior to exit as follows:</p> <p>1. Interview, on 04/09/15 at 4:48 PM, with the Clinical DON revealed she notified Resident #21's physician and family, DCBS and OIG the day the allegation was made, on 04/01/15. Review of the facility's investigation revealed the notifications were made on 04/01/15.</p>	F 520	<p>The contract consultant observes the QA process monthly, including audit tools for at least 3 months, beginning 5/4/15 to ensure Quality Assurance Performance Improvement Committee is functional and the meetings address the identified needs of the facility. The QA Committee reviews audits (and takes action if needed) related to the results of the audits. These include audits which were initiated in response to the deficiencies. The reports will be presented by the QA Director or Compliance Auditor.</p>	6/9/15	

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F 520	Continued From page 202 2. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she interviewed and assessed Resident #21 on 04/01/15 for behavioral and psychosocial concerns. The resident was not tearful and did not express any anxiety. Review of the facility's investigation revealed the Clinical DON interviewed the resident on 04/01/15. 3. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she interviewed Resident #21 on 04/02/15. 4. Interview, on 04/09/15 at 5:03 PM, with the Administrative DON revealed the alleged CNA was placed on administrative leave on 04/02/15. Interview with CNA #5, on 04/03/15 at 8:40 AM, revealed the facility suspended her on 04/02/15. 5. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, the Administrative DON, on 04/09/15 at 5:03 PM, and the Administrator, on 04/09/15 at 5:14 PM, revealed the Administrator trained the Clinical DON and Administrative DON, on 04/03/15, on the abuse policy and collecting statements jointly, with verbalized understanding. Review of the training records revealed, on 04/03/15, the Administrator trained the Clinical DON and Administrative DON on the abuse policy and collecting statements jointly. 6. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she developed the investigation checklist, on 04/03/15, to ensure every step had been taken during an investigation. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she had been trained by the Administrative DON on the use of the investigation checklist and completed by	F 520		
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F 520	Continued From page 203 either DON. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed he approved the new Investigation Checklist. Review of the Investigation Checklist revealed an effective date of April 2015.	F 520			
	<p>7. Interview, on 04/09/15 at 4:48 PM, with the Clinical DON and, on 04/09/15 at 5:03 PM, with the Administrative DON revealed the Administrative DON revised the Allegation Log to include two (2) sets of signatures for review by nursing administration. The Administrative DON trained the Clinical DON how to use the log. Interview, on 04/09/15 at 5:14 PM, with the Administrator revealed he approved the revised Allegation Log which required both DONs to initial they had reviewed the allegations. Review of the Allegation Log revealed it contained Nursing Administration review and was revised April 2015, and was reviewed by the Clinical DON, Administrative DON, the Clinical Support Services, and Administrative Nursing Assistant.</p> <p>Review of the revised allegation log revealed a place for two (2) signatures were added on 04/03/15.</p> <p>8. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she interviewed other interviewable residents regarding possible issues with care and abuse. Review of the Resident Interviews for Resident #21's investigation, dated 04/08/15, revealed, on 04/07/15, the Administrative DON interviewed fourteen (14) interviewable residents if there were any issues or concerns with staff. No concerns were noted.</p> <p>Interview, on 04/09/15 at 4:25 PM, with the</p>				

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F 520	Continued From page 204 Treatment Nurse revealed she completed skin assessments of eight (8) non-interviewable residents, on 04/08/15, on the 3rd floor. She stated she completed one side of the unit and the Outreach Technician (ORT) nurse completed the other side of the unit with no concerns noted. Review of six (6) skin assessments and two (2) wound assessments revealed skin assessments were completed on 04/08/15. Interview with Resident #4, on 04/01/15 at 10:25 AM; Resident #12, on 03/31/15 at 8:46 AM; Resident #13, on 03/31/15 at 7:47 AM; Resident #15, on 04/01/15 at 10:20 AM; and, Resident #16, on 03/31/15 at 9:30 AM, revealed no concerns with staff interactions with the residents. 9. Interview, on 04/09/15 at 5:03 PM, with the Administrative DON revealed she reviewed facility allegations for the last year, for a total of twenty-five (25) investigations with no concerns noted. Review of a statement by the Administrative DON, dated 04/07/15, revealed twenty-five (25) investigations were reviewed in the last twelve (12) months by the Administrative DON, with no concerns noted. Review of four (4) investigations revealed no regulatory violations for Residents #31, #32, #33 and #34. 10. Interviews on 04/09/15 with a total of fifty (50) employees revealed: seventeen (17) CNAs (CNA #13 at 1:56 PM, CNA #3 at 1:57 PM, CNA #22 at 2:00 PM, CNA #21 at 2:06 PM, CNA #8 at 2:12 PM, CNA #9 at 2:20 PM, CNA #17 at 2:21 PM, CNA #15 at 2:52 PM, CNA #14 at 2:46 PM, CNA #16 at 3:05 PM, CNA #19 at 3:05 PM, CNA #10 at 3:09 PM, CNA #18 at 3:12 PM, CNA #20 at 3:15 PM, CNA #11 at 3:17 PM, CNA #23 at 3:20 PM, CNA #12 at 3:31 PM), six (6) LPNs (LPN #1 at 3:07 PM, LPN #5 at 2:47 PM, LPN #3 at 2:45 PM,	F 520			

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F 520	Continued From page 205 LPN #9 at 3:07 PM, LPN #10 at 3:30 PM, LPN #8 at 2:18 PM, RN #4 at 2:09 PM, five (5) Unit Managers (UM/RN #2 at 2:00 PM, UM/RN #3 at 2:27 PM, UM/RN #6 at 3:00 PM, UM #1 at 3:00 PM, UM/RN #7 at 3:35 PM), three (3) housekeepers (Housekeeper #2 at 2:09 PM, Housekeeper #3 at 2:15 PM, Housekeeper #4 at 2:15 PM), a CSR at 2:27 PM, a Dietary Aide at 2:31 PM, Central Supply at 2:51 PM, Rehabilitation Secretary at 2:40 PM, Rehabilitation Director at 2:42 PM, the Nutrition Services Director at 1:58 PM, the Social Services Director at 2:11 PM, the Activities Director at 2:24 PM, RAI Coordinator at 2:34 PM, HR Director at 2:43 PM, Receptionist at 3:02 PM, Compliance Auditor at 3:31 PM, QA Director at 3:45 PM, Rehab Manager at 3:55 PM, Treatment Nurse at 4:25 PM, House Supervisor at 4:33 PM, Clinical DON at 4:48 PM, and the Administrative DON at 5:03 PM revealed they had all received abuse training within the last week; they were aware of the types of abuse; when to report abuse; and, to who to report alleged abuse. Review of the training records revealed three hundred and eleven (311) staff had completed post tests between 04/02/15 and 04/08/15. Interview with the HR Director, on 04/09/15 at 2:43 PM, revealed all staff had been trained on abuse except those staff on vacation or leave. The HR Director stated a sign was posted at the time clock and a letter was mailed to those staff not yet trained, that they must receive training prior to working. Observation, on 04/09/15 at 4:04 PM, of the time clock revealed a sign posted with thirteen (13) staff names to obtain abuse training prior to going to their unit. Review of the letter sent to staff revealed it was dated 04/08/15 from the HR Director that stated staff must receive the	F 520			

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F 520	Continued From page 206 abuse training and answer the questionnaire before they started work. Review of the facility's staff roster revealed the letter was mailed to ten (10) employees, who were either sick, on vacation, or leave of absence.	F 520			
	<p>11. Interview with the Compliance Auditor, on 04/09/15 at 3:31 PM, and the QA Director, on 04/09/15 at 3:45 PM, revealed they would review the Allegation Log for completion and signatures weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter. They stated the audits would go to the QA meetings for review. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed the Compliance Auditor would conduct audits of the Allegation Log and report the findings to the QA Committee.</p> <p>12. Interview, on 04/09/15 at 3:31 PM, with the Compliance Auditor and, on 04/09/15 at 3:45 PM, with the QA Director revealed either would audit the Investigation Checklist weekly for four (4) weeks, monthly for three (3) months, then quarterly for a year with results to QA the Committee. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed the Compliance Auditor would audit the Investigation Checklist and report to the QA Committee. Review of the Investigation Checklist revealed an inception date of 04/03/15.</p> <p>13. Review of the third floor care plan updates revealed, on 04/03/15, the care plan for Resident #21 was updated by the RAI Coordinator.</p> <p>14. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she reviewed resident</p>				

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F 520	Continued From page 207 behavior and antipsychotic care plans on 04/08/15, and then all residents, checking if the care plan had been updated, initiated, and implemented, with no concerns noted. Review of care plan audits for all six (6) floors, dated 04/07/15 revealed all care plans were reviewed for residents on each floor of the facility with 119 care plans revised. 15. Interview with the Social Services Director, on 04/09/15 at 2:11 PM, the RAI Coordinator, on 04/09/15 at 2:43 PM, with the UM on the 2nd floor (RN #2 on 04/09/15 at 2:00 PM and RN #3 on 04/09/15 at 2:27 PM), the UM on the 3rd floor, on 04/09/15 at 3:00 PM, and the Administrative DON, on 04/09/15 at 5:03 PM, revealed they received care plan training this week and was conducted by the Administrative DON, that included who initiated and updated the care plan, and how to implement the care plan, with verbal competency. Review of the care plan training records revealed care plan training included who initiated and updated the care plan, when the care plan should be revised, and who was responsible to implement the care plan. 16. Interview, on 04/09/15 at 2:00 PM, with UM/RN #2; on 04/09/15 at 2:27 PM, with UM/RN #3; and, on 04/09/15 at 3:00 PM, with UM #1 revealed walking rounds were conducted throughout the shift, but they did not document those rounds. The UMs stated they were observing direct staff to ensure care was provided according to the resident's care plan. Review of care plans revealed Resident #4's care plan was revised on 04/07/15, based on the UM rounds, to reflect the current placement in isolation. 17. Interview with the RAI Coordinator, on	F 520			

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F 520	Continued From page 208 04/09/15 at 2:34 PM, revealed she held a Program of Care meeting on 04/08/15 to review and ensure resident care plans were appropriate. Meetings would be held weekly, with discussion of certain residents each week, with all residents discussed quarterly. Interview with the Nutrition Services Director, on 04/09/15 at 1:58 PM; the Social Services Director, on 04/09/15 at 2:11 PM; the Activities Director, on 04/09/15 at 2:24 PM, revealed their assistants would attend the Program of Care meetings; however, the Directors would attend in the assistants place when needed, and would discuss resident care plan interventions. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed the Program of Care meetings would review that resident care plans were up to date, make any needed changes, and interventions were implemented. 18. Interview, on 04/09/15 at 3:31 PM, with the Compliance Auditor revealed she would audit the Program of Care meetings three (3) times a week for four (4) weeks, three (3) times a month for one (1) quarter, then quarterly and give the results to the DON for the QA Committee. 19. Interview with the Compliance Auditor, on 04/09/15 at 3:31 PM, revealed she would conduct ten (10) chart audits each month for three (3) months, then quarterly to ensure care plans were updated and interventions performed, with discrepancies corrected by the UM. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed the Compliance Auditor would complete ten (10) chart audits and ensure the residents' care plans interventions were implemented; the UM would correct any issues immediately. She stated results would be taken to the QA	F 520			

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F 520	Continued From page 209 Committee. Review of the Care Plan Monitoring Tool, dated April 2015, revealed it included review of the resident care plan, if the care plan had been updated, observations, concerns, if the care plan was followed, and Assistant UM or UM aware-of result.	F 520			
	<p>20. Interview with the Nutrition Services Director, on 04/09/15 at 1:58 PM, the Social Services Director, on 04/09/15 at 2:11 PM, the Activities Director, on 04/09/15 at 2:24 PM, the HR Director, on 04/09/15 at 2:43 PM, the Compliance Auditor, on 04/09/15 at 3:31 PM, the QA Director, on 04/09/15 at 3:45 PM, the Rehab Manager, on 04/09/15 at 3:55 PM, the Medical Director, on 04/09/15 at 4:07 PM, the Treatment Nurse, on 04/09/15 at 4:25 PM, the Clinical DON, on 04/09/15 at 4:48 PM, the Administrative DON, on 04/09/15 at 5:03 PM, and the Administrator, on 04/09/15 at 5:14 PM, revealed they attended QA meetings, with three (3) held, and discussed the Immediate Jeopardy (IJ), corrective actions, care plans, new checklists, and training. Review of sign in sheets that included review of the IJ and corrective actions revealed QA meetings were held on 04/03/15, 04/06/15, and 04/08/15.</p> <p>An abbreviated survey conducted 04/28/15 investigating KY 23169 and KY 23245 determined the facility failed to implement the corrective actions of the AOC dated 04/09/15. Review of the acceptable AOC, dated 04/09/15, revealed the abuse allegation checklist and abuse allegation log would be audited by the Compliance Auditor and the results would be brought to the QA committee.</p>				

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F 520	Continued From page 210 Review of the newly developed checklist to be utilized by the facility to ensure abuse investigations were completed, (which was an intervention on the AOC) revealed no date when it was completed and only checks on the forms without any additional information provided.	F 520			
	<p>Interview with the Compliance Auditor, on 04/30/15 at 1:15 PM, revealed when she reviewed the newly developed checklist she only looked for the check marks and did not review the content of the investigation. In addition, she stated the audits of the abuse investigation checklist were not taken to the Quality Assurance (QA) meeting on 04/27/15. Interview with the Administrator, on 04/30/15 at 3:45 PM, validated the audits of the checklist and the abuse logs were not discussed at the 04/27/15 QA meeting.</p> <p>Immediate Jeopardy was determined not to be removed on 04/09/15 as alleged. The facility was notified of this finding on 04/30/15. The facility took the following actions to remove the Immediate Jeopardy on 05/06/15 as follows:</p> <p>1. The Clinical DON made notification on 04/20/15 of the allegation (KY 23169) to Resident #36's family, physician, OIG and DCBS. The Administrative DON made notification of the allegation of abuse (KY23245) to Resident #37's family and Physician on 04/27/15. Notification to the OIG and DCBS was made on 04/28/15.</p> <p>2. On 04/21/15, a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor with no injuries consistent with abuse noted. Fifty-six (56) skin assessments were completed on non-interviewable residents by Unit Managers,</p>				

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F 520	Continued From page 211 Assistant Managers, and Staff Development Nurse as of 05/04/15. No issues were found. 3. 05/04/15, one hundred thirty (130) residents were interviewed by Social Services, and the RAI Coordinators to ensure there were no unresolved or uninvestigated allegations of abuse. No issues were identified. 4. The abuse allegation checklist was revised on 04/28/15 by the Clinical DON to reflect name, date, and time of actions, with a space for narrative documentation to record all actions taken during the abuse investigation. 5. On 05/01/15, the facility obtained the services of a consultant company to provide assistance with training, policy revision, QA and ongoing oversight and consultation. These consultant employees included Nurses, therapists, and Administrators. The facility's Administrative DONs, Human Resources Director, and Assistant Director of Nurses met with the consultants and revised the abuse policy to reflect procedures for immediate protection of residents by removal of the alleged perpetrator from patient care and reporting immediately allegations of any abuse to the state agencies. All staff would receive training on the new Abuse policy revisions and no staff would work past 05/05/15 without receiving the training. This would include agency staff. 6. On 05/05/15, education was provided by the contracted consultant on requirements for abuse allegation reporting and investigation with competency. No staff would be allowed to work past 05/05/15 without receiving the training. This would include agency staff. As of 05/05/15, two hundred ninety-seven (297) employees had been	F 520			

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F 520	Continued From page 212 trained. 7. On 05/04/15, the facility implemented a new Nurses' Abuse Allegation Investigation Protocol. The protocol was a step by step reference for nurses and House Supervisors to be used when a resident alleged abuse. The protocol was posted in visible locations on all nursing units and included in all staff education. (Attachment B) 8. On 05/04/15, a QA meeting was held to review the alleged deficient practice and plans of actions established to correct the practices. The consultant observed the QA meeting. Members present included the Administrator, Consultant, Social Services, Medical Director, DONs and other Department Directors. The Administrator established a weekly QA meeting that included review of the deficiencies cited. 9. On 05/04/15, the Elder Justice Act reporting notification requirements was added to the admission packet. The revised Abuse policy and Elder Justice Act information was placed in a binder at the receptionist desk. 10. On 05/05/15, five (5) random staff and resident interviews would be conducted weekly by Social Services and Nursing Administration to ensure there were no unresolved/investigated abuse allegations and staff understanding of reporting requirements. 11. On 05/04/15, the contracted consultant educated the Administrator and made observations at the facility to ensure the Administrator was administering the facility in	F 520			

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F 520	Continued From page 213 accordance with professional standards and per his job description included ensuring a system was in place to protect residents from abuse and neglect. 12. Beginning 05/01/15, a consultant would conduct weekly visits for four weeks then monthly visits to ensure the Administrator followed professional standards and job description ensuring systems remained in place for reporting and investigation of allegations of abuse and neglect per established plan of correction. The Administrator established weekly administrative consultative visits with the consultants. 13. The contract consultant re-educated the Administrator, on 05/04/15, on the requirements of a functional QA process to include delegation of action items for identified concerns including oversight of entire AOC and implementation of systems and follow-up to ensure corrections were made and reviewed with the Interdisciplinary Team (IDT). 14. Beginning 05/04/15 the Human Resources Director would update the Administrator daily of the status of staff training on abuse. 15. On 05/05/15, the Administrator amended the agenda for the daily quality meeting with the IDT, to address deficiencies cited. This included reviewing audits, education, and ongoing monitoring to determined effectiveness of current actions. 16. Weekly QA meetings that began on 05/04/15, was held to review identified concerns regarding any issues with the Plan of Correction and follow-up to ensure corrections were sustained.	F 520			

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F 520	Continued From page 214 The meeting would consist of at a minimum the Administrator, Director of Nursing, Social Services, Assistant Director of Nursing, and other Department Directors. The contract consultant would observe the QA process monthly, including audit tools (attachment E) for at least three (3) months to ensure Quality Assurance Performance Improvement Committee was functional and meeting the identified needs of the facility. The QA committee would consist of the Administrator, DONs, ADON, Social Services, and the Medical Director attending at least quarterly. When the Medical Director was present, they would review a sample of residents' abuse allegations for effectiveness in the revised processes. The QA meeting would review audits (and take action if needed) related to the deficiencies. Theses audits would include resident interviews and skin audits conducted on 05/04/15 and abuse audits which began on 04/08/15 and are ongoing. The reports would be presented by the Compliance Auditor. The State Survey Agency validated the removal of Immediate Jeopardy on 05/13/15 prior to exit as follows: 1. Review of the clinical record and facility investigation validated the Clinical DON notified Resident #36's family, physician, OIG, and DCBS on 04/20/15. Review of the fax verification revealed the OIG was notified on 04/20/15 at 4:09 PM. Review of the clinical record and facility investigation revealed the Administrative DON	F 520			

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F 520	Continued From page 215 notified Resident #37's family and physician on 04/27/15. Review of the faxed verification sheet revealed notification to the OIG on 04/28/15 at 3:11 PM. Review of the Department of Community Based Services (DCBS) intake summary revealed the notification was received on 04/29/15. Interview with the Administrative DON, on 04/29/15 at 2:24 PM, revealed the facility's fax machine was broken on Monday, April 27, 2015 and she failed to provide notification via telephone. 2. Review of facility's investigation revealed a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor on 04/21/15, with no injuries consistent with abuse. Review of the skin assessments conducted by the Unit Managers, Assistant Managers, and Staff Development Nurse through 05/04/15, revealed fifty-three (53) skin assessments were conducted for residents with a BIMS score less than eight (8). 3. Review of the resident interview forms revealed Social Services, and the RAI Coordinators conducted one hundred thirty-three (133) resident interviews by 05/04/15. No resident alleged abuse. The interview form included a questionnaire for staff to determine if the resident had any mood or behavioral changes. None was noted. 4. Interview with the Clinical DON, on 05/13/15 at 4:20 PM, revealed the abuse checklist was revised to give more details to ensure the investigation was conducted and timely. In addition, the Compliance Auditor would be able to determine if the investigation was completed timely and according to the facility's Abuse policy.	F 520			

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F 520	Continued From page 216 Review of the checklist for the abuse investigation for Residents #37, 38, 39, 40, 41, 42, and #43 revealed the abuse checklist was completed with details of notification (including the state agencies), protection of the resident, resident and staff interviews, meeting with DONs and Administrator, and when copy of the checklist was sent to the QA committee. Residents #38, 39, 40, 41, 42, and 43 was completed after the facility was notified of the Immediate Jeopardy. 5. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff and assistance with development of the AOC, and QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15. He stated the Abuse policy was revised on 05/04/15 with input from the consultant services. Review on 05/13/15, of the revised Abuse policy, revealed language changes in how the residents would be protected included the employee suspected of abuse would be removed from the unit and patient care immediately. The House Supervisor or Nursing Administration would assure the employee clocked out and left the facility. Employees who witnessed potential abuse are instructed to immediately intervene to protect the resident, the alleged perpetrator should not be left alone with the resident. All employees were required to immediately report any observations, suspicion, or information of suspected or actual abuse, neglect, or misappropriation of property to the House	F 520			

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F 520	Continued From page 217 Supervisor. House Supervisor or Nursing Administration would report all allegations of abuse or neglect to DCBS, Police, and OIG immediately. Four (4) abuse investigations were reviewed on 05/13/15 for Residents #40, 41, 42 and #43 and validated the facility used the abuse investigation checklist and the QA investigation tool. Based on residents' interviews, record review, and review of the facility's investigation, no problems were found with these abuse investigations. Review of the training records revealed all working staff had been trained on the new abuse policy. Observations on 05/13/15 of the second, third, fourth, fifth, and seventh floors revealed the revised Abuse policy of 05/04/15 had been placed in the policy binder at each nurse's station and the binder was easily assessable to all staff for review. 6. Review of the training records and the staff roster validated all working staff had been trained on the revised Abuse policy by 05/05/15. The training was provided by the consultant via classroom on 05/04/15 and through a thirty (30) minute video through 05/05/15. A pre and post test was required. Interviews conducted on 05/13/15 with CNA #25, at 3:05 PM, CNA #2 at 2:30 PM, CNA #27 at 2:35 PM, CNA #28 at 3:30 PM, CNA #30 at 2:42 PM, CNA #32 at 2:44 PM, CNA#31 at 2:47 PM, CNA student #1, at 3:43 PM, and CNA student #2 at 3:50 PM validated they had received recent training on abuse. The staff could identify abuse, how to protect the resident and when and whom	F 520			

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F 520	Continued From page 218 to report abuse. Interview on 05/13/15, with the Unit Manager for the Fourth floor at 2:49 PM, Third floor at 2:50 PM, Second floor at 3:20 PM, and Seventh floor at 3:43 PM-revealed the managers received abuse training with the revised Abuse policy. The managers knew the location of the Abuse policy and the new Nurse' Abuse Allegation Protocol was posted at each nurses' station. In addition, interview with LPN #5 at 3:07 PM, LPN #11 at 3:15 PM, LPN #12 at 2:40 PM, and LPN #1 at 3:09 PM revealed they had received abuse training with a pre and post test. Interview with the Unit Sectary for the Second floor, at 3:40 PM, and a Central Supply person at 3:44 PM revealed they received training on abuse and knew when and whom to report the abuse. 7. Observation of the Fourth floor, on 05/13/15 at 2:49 PM, Third floor at 2:50 PM, Second floor at 3:20 PM, fifth floor at 3:35 PM, and Seventh floor at 3:43 PM revealed the Nurses' Abuse Allegation Investigation Protocol was posted at the nurses' station. Interview on 05/13/15, with the UM for the Fourth floor at 2:49 PM, Third floor at 2:50 PM, Second floor at 3:20 PM, and Seventh floor at 3:43 PM, revealed the managers received training on the new Nurses' Abuse Allegation Investigative Protocol tool and understood how to follow. 8. On 5/13/15 at 5:05 PM, a review of the sign in sheet for QA meetings revealed a QA was held on 05/04/15 with the Consultant present. Review of the QA agenda revealed the deficiencies and plan of actions were discussed.	F 520			

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F 520	Continued From page 219 Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed the QA committee reviewed the Abuse policy and survey issues with plan of actions. See attachment F. The Administrator stated he would have weekly QA meetings to review deficiencies cited. Review revealed the facility held another QA meeting on 05/11/15 that included the Medical Director. Review of the May 11, 2015 QA meeting agenda revealed the QA committee would review the AOC, action plans and audits 9. Observation upon entrance of the facility, on 05/13/15 at 12:45 PM, revealed a binder at the receptionist desk that included the revised Abuse Policy and Elder Justice Act information. The binder was available for the public to view. Review of the admission packet revealed the information on the Elder Justice Act was included. 10. On 05/13/15 at 4:45 PM, a review of the five random staff and resident interviews were validated completed on 05/05/15. No concerns was voiced. Interview with Social Worker #1, on 05/13/15 at 4:50 PM, revealed she had received training on the revised Abuse policy. She stated she conducted some of the resident and staff interviews. She received no concerns. She felt the new system was more effective because everyone was more aware of abuse and knows how to protect the residents and when to report the abuse. 11. Review of attachment F and the copy of the Administration training validated the Administrator was re-educated by the consultant on 05/04/15.	F 520		

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F 520	<p>Continued From page 220 See attachment F and copy of training.</p> <p>Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff; assistance with development of the AOC; and, QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15 for administrative visits.</p> <p>The Administrator stated he had received training on how to conduct a functional QA meeting to identify concerns and provide oversight of the AOC and implementation of systems. He stated he meets with the IDT team daily on each floor. He stated the Human Resources Director informed him each morning how many employees had been trained and how many need the training.</p> <p>Interview with the Human Resources Director, on 05/13/15 at 4:37 PM, revealed all staff working had been trained.</p> <p>12. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant's services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff and assistance with development of the AOC, and QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15 for administrative visits.</p> <p>13. Interview with the Administrator, on 05/13/15 at 6:20 PM revealed he had received training on how to conduct a functional QA meeting to</p>	F 520			

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F 520	Continued From page 221 identify concerns and provide oversight of the AOC and implementation of systems. He stated he meets with the IDT team daily on each floor. He stated the Human Resources Director informs him each morning how many employees have been trained and how many need the training.	F 520			
	<p>14. Interview with the Human Resources Director, on 05/13/15 at 4:37 PM, revealed she reported daily to the Administrator how many staff had been trained. She stated all staff had been trained by 05/05/15 with exception of those on medical leave.</p> <p>15. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed he changed the agenda for the daily meetings with the IDT team to include the UM on each floor. They discussed the deficiencies cited and plan of actions. This would include any audits, monitoring to ensure actions plans were implemented and compliance was achieved. In addition, they discuss problems specific to that floor would be discussed.</p> <p>16. On 5/13/15 at 5:05 PM, a review of the sign in sheet for QA meetings revealed a QA was held on 05/04/15 with the Consultant present. Review of the QA agenda revealed the deficiencies and plan of actions were discussed. Those in attendance included the Administrator, DONs, Social Services, ADON, Medical Director and other Department Directors.</p> <p>Attachment F validated the Consultant was present during the QA meeting. Review of the May 11, 2015 QA meeting agenda revealed resident interviews and skin audits conducted on 05/04/15 and abuse audits which began on 04/08/15 were reviewed. The reports would be</p>				

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F 520	Continued From page 222 presented by the Compliance Auditor. Interview with the Compliance Auditor, on 05/13/15 at 5:30 PM, revealed she received training on the revised Abuse policy. She stated when she reviewed the abuse investigation checklist and the abuse log she was now looking at the entire abuse investigation to ensure everything was completed according to the checklist. At the QA meetings she reported to the committee how many abuse investigations were completed and her findings on the audits. She still checked the abuse log to ensure two people had reviewed the abuse investigation.	F 520			