

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

PRINTED: 11/10/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/27/2015
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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1581 NEWTON AVE. BOWLING GREEN, KY 42104
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F 000	INITIAL COMMENTS	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare Requirements.	
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure one (1) resident, in the selected sample of four (4) residents (Resident #1), was free from abuse by a family member who provided care for the resident on a daily basis. Review of a surveillance video revealed the resident's family member (niece) holding his/her arms and attempting to force feed the resident several bites of food. When the resident became combative, he/she was kicking at the family member which caused the wheelchair to move backward. Additionally, the family member was observed to grab the wheelchair and pull it back under the table, which caused the resident's body to move backward and then forward. The facility Administrator notified the police to ensure the family member did not return to the facility	F 223		11-27-15 SS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glenn Sheehan TITLE: Administrator (X6) DATE: 11-16-15

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

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F 223	<p>Continued From page 1</p> <p>and initiated an investigation of the incident. Review of staff statements revealed the family member had been rough with the resident's care, forced the resident to urinate before she left for the day, and was observed sticking her fingers in the resident's rectum to check for stool and cleanliness.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Care Plans Administrative Policies" (Revised January 2002), revealed:</p> <ol style="list-style-type: none"> Care plan goals and objectives are defined as the desired outcome for a specific resident problem. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives were established. Care plans will be modified accordingly. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and a) are resident oriented; b) are behaviorally stated; c) are measurable; and d) contain timetables to meet the resident's needs in accordance with the comprehensive assessment. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. Goals and objectives are reviewed and/or revised a) when there has been a significant change in the resident's condition; b) when the desired outcome has not been achieved; c) when the resident has been readmitted to the facility from a hospital/rehabilitation stay; and d) at least 	F 223	<p><u>F223</u></p> <p><u>Residents affected</u></p> <ol style="list-style-type: none"> Resident #1 was immediately kept from niece. Administrator called Bowling Green Police on 10/5/15 after viewing video from 10/3/15 allowing police to ban niece and keep her from returning to facility. Resident #1 was assessed by ADON, Police officer and clinical supervisor on 10/5/15 with no areas noted. Resident was monitored for changes in condition by nursing daily for 2 weeks by ADON, DON and/or charge nurse. Picture of family member placed at time clock with instructions on calling police immediately then Administrator if she returns to the facility by the Administrator on 10/5/15. For one week this information on niece was passed in the 24 hour nursing report stating to call the police if she attempted to return to the facility starting 10/5/15. All staff was educated on contacting police immediately if niece returned to the facility and then to call facility Administrator by DON, 	11/25/15 <i>[Signature]</i>	

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F 223	<p>Continued From page 2 quarterly.</p> <p>6. The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.</p> <p>Review of the facility training (Silverchair Learning), revealed "Resident abuse can occur at any time and in any location. The disturbing thing about resident abuse is that it is usually committed by someone who is trusted by the resident. Facility employees, friends of a resident, and even resident family members may abuse a resident."</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses to include Peripheral Vascular Disease (PVD), Dementia without Behavioral Disturbance, Major Depressive Disorder, Muscle Weakness, Hypertension (HTN), Constipation, Diabetes Mellitus (DM) with Polyneuropathy, and Above the Knee Amputation (AKA). Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/04/15, revealed the facility determined the resident was cognitively impaired with a Brief Interview Mental Status score of four (4). He/she was not interviewable and required extensive assistance with all activities of daily living (ADLs).</p> <p>Review of the facility's investigation, dated 10/08/15, revealed Resident #1's niece presented a nine (9) page hand written document to the Administrator on 10/05/15, which contained a time line of staff's actions in the facility's dining room during a meal service on 10/03/15. Additionally, she presented plates of food she had</p>	F 223	<p>ADON and Administrator starting on 10/5/15 and completed on 10/23/15.</p> <p><u>Residents Potentially Affected</u></p> <ol style="list-style-type: none"> No Residents were identified with family members providing their ADL care by Social Worker, ADON, DON and/or Administrator on 11/18/15. 100% of all residents were interviewed to identify any abuse and/or neglect that had not been reported by Social Services and Admissions on 11/19/15. <p><u>Measures/Systematic Changes</u></p> <ol style="list-style-type: none"> All staff have been reeducated on importance of reporting abuse or neglect to immediate supervisor and to the abuse coordinator, the Administrator, the abuse and neglect policy which includes intervening immediately by removing resident from situation and if there were any current concerns to report, and the ban on the niece of Resident #1 and to contact police immediately if she comes to the facility given by the Administrator on 	11/20/15 <i>[Signature]</i>	

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F 223	<p>Continued From page 3</p> <p>taken out of the facility. The resident's niece alleged that staff did not attempt to feed the resident for a long enough period of time. Further review of the investigation revealed the Administrator viewed the video surveillance recording of the meal. The Administrator was unable to verify the accuracy of the time line of staff actions presented by the resident's niece. Review of the recording revealed the resident's niece going in and out of the dining room, and at one (1) point, took Resident #1's plate of food, placing the plate of food in a bag, and leaving the building with the bag. Within a few minutes, she returned and had the kitchen prepare another tray. She sat beside Resident #1 and wrote information on a tablet until all but one (1) resident left the dining room, at which time she held Resident #1's arms down and pushed the spoon of food into the resident's mouth. The resident kicked and hit at his/her niece causing his/her wheelchair to roll backward. She then grabbed the wheelchair and pulled the resident back to the table with enough force that his/her body moved backward in the wheelchair, and then forward. She continued to force feed the resident four (4) to five (5) more times. She then took the food tray to the resident's room and came back to get the resident.</p> <p>Further review revealed the Administrator obtained staff statements and notified the police to ensure the resident's niece did not return to the facility. The police viewed the video recording, and were aware of staff's statements alleging the resident's niece force fed the resident, about the niece being rough with the resident's penis during incontinent care, and about the niece sticking her fingers in the resident's rectum checking for stool. Interview with the Police Officer revealed he</p>	F 223	<p>10/30/15. Staff will be unable to work until completing the education on 11/21/15 if missed on 10/30/15.</p> <p>2. Staff Educated to report any family members requesting to give care to the resident to DON, ADON and/or Administrator on 11/21/15 by Administrator. Staff will be unable to work until completing the education on 11/21/15.</p> <p>3. Family members identified to be requesting to give care to the resident will have staff member present during care and will be placed on ADL care plan by licensed nurse that family member assist with their care.</p> <p><u>Monitoring Changes</u></p> <p>1. New Staff to be educated on abuse and neglect policy during orientation. All staff to be educated twice yearly on abuse and neglect policy and as needed for updates to policy. Administrator to audit abuse and neglect policy training and Speak with 10 residents to ensure any abuse or neglect has been reported monthly times (3) three months and</p>	11/21/15 <i>[Signature]</i>	

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F 223	<p>Continued From page 4</p> <p>located the niece and she was legally banned from the facility for two (2) years.</p> <p>Interview with the Director of Nursing (DON), on 10/22/15 at 8:45 AM, revealed Resident #1's family member was at the facility daily and provided care for Resident #1. She stated the family member spent a half hour or so a day talking to the Administrator, and expressed her dissatisfaction with the care provided by the facility staff. The DON revealed that, at times, the family member's discussions would be personal and not about the resident. She revealed the family member had "always been intense" and had recently taken a urine soaked brief to a facility employee's house to show the employee, and all the while blocking a lane of traffic, and did the same with a grilled cheese sandwich. The DON stated the family member was very intense and "bizarre", and had been in a "manic state" the last couple of weeks, and was also taking notes about activities of staff.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 10/22/15 at 11:00 AM, revealed Resident #1's family member came to the facility two (2) times daily and provided care for Resident #1. The CNA revealed the resident's family member would shower the resident, after the staff had already showered the resident, and would tell the staff she felt the resident was not clean enough. CNA #1 stated the resident's family member provided incontinent care and put a clean Incontinent brief on the resident "very tightly" so urine would not leak out. CNA #1 also stated the last couple of weeks the family member got rough during care, and it was like "she was trying to scrub his/her skin off". CNA #1 revealed the family member had been forceful while feeding the resident even</p>	F 223	<p>quarterly times (1) one quarter to ascertain that facility is educating on abuse and neglect policy.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, Pharmacy, Social Services, Medical Director, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>		

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F 223	<p>Continued From page 5</p> <p>after the resident would say he/she did not want anything. CNA #1 stated "we said something to the Administrator" and were told she would speak to the resident's family member.</p> <p>Interview with CNA #2, on 10/22/15 at 11:30 AM, revealed Resident #1's family member would provide care for the resident for an hour, and then spend four (4) hours watching staff. CNA #2 stated one (1) day recently, the family member "acted like the world had ended because Resident #1 was the last resident to be taken to the dining room". The CNA stated the resident's family member kept documenting in a book and asking staff names. CNA #2 stated "it was like something changed and she snapped this last weekend". CNA #2 revealed the family member had followed staff to the smoking area outside the facility demanding the CNAs return inside the facility and transfer Resident #1 for her.</p> <p>Interview with CNA #3, on 10/22/15 at 2:05 PM, revealed Resident #1's family member always insisted on a second bath or shower for Resident #1, and the resident would "cuss" the family member. CNA #3 revealed the resident's family member would take fingers full of food and place in the resident's mouth and try to make him/her eat the food. Additionally, the CNA revealed Resident #1's family member "put Vaseline in the resident's butt to clean him/her out". CNA #3 stated the resident's niece was angry with staff all the time and told staff she was going to bring her lawyer to the facility. CNA #3 stated she told a nurse; however, did not recall who she told, about three (3) days before the resident's niece was banned from the facility. CNA #3 stated she felt the family member was trying hard to care for the resident, but seemed to be "overwhelmed" trying</p>	F 223			

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F 223	<p>Continued From page 6 to take care of him/her.</p> <p>Interview with CNA #4, on 10/22/15 at 2:20 PM, revealed Resident #1 was usually cooperative with care unless the resident's family member was present. She stated "the family member showered the resident even though the resident already had a shower", and insisted on providing the resident's care; however, she would "put the call light on for staff to come and transfer him/her". The CNA stated the resident would get "mad and agitated" after the family member provided care. CNA #4 revealed the resident's family member spoke about Resident #1 being constipated and would want medicine administered to him/her.</p> <p>Interview with CNA #5, on 10/22/15 at 3:20 PM, revealed Resident #1 was usually cooperative with care unless the resident's family member (niece) was present. She stated the resident would yell at his/her niece during care, as she was providing the care. CNA #5 revealed Resident #1 was pleasant and ate if he/she was hungry; however, the resident's niece sometimes became upset with staff, stating the resident needed "more". CNA #5 stated the resident's niece "would go up the rectum" when she provided incontinent care, and Resident #1 would state "tell her to quit" and cuss her. Additionally, CNA #5 stated "they (someone in Administration) would talk to the niece, and she would get better; however, she would go back to it". She revealed when Resident #1 would say he/she "was done" during a meal while his/her niece was feeding him/her, the niece tried to keep feeding him/her, and the resident would get upset.</p> <p>Interview with CNA #6, on 10/22/15 at 4:15 PM,</p>	F 223			

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F 223	<p>Continued From page 7</p> <p>revealed Resident #1's niece was loud at times and demanded staff's presence. CNA #6 revealed the resident's niece had been to the Administrator saying "the staff did not do this or that", but she has never been reprimanded for anything. CNA #6 stated the resident's niece wanted the incontinent brief "very snug" and would put Vaseline on the resident from head to toe.</p> <p>Interview with CNA #7, on 10/23/15 at 7:45 AM, revealed she could not recall a day when Resident #1's niece was not at the facility. She stated the resident's niece expected the staff to "drop everything" when she walked in the door. CNA #7 revealed the resident's niece would go from resident room to resident room, opening the door looking for staff. CNA #7 revealed the family member (niece) had recently been worse by dumping the resident's food in a bag and putting the bag in her car. CNA #7 recalled a time when the family member was in the resident's dining room and snapped her fingers stating "don't make the nig**r in me come out". CNA #7 stated it made her uncomfortable and was concerned about other residents present in the dining room.</p> <p>Interview with CNA #8, on 10/23/15 at 10:20 AM, revealed she was present when Resident #1's family member (niece) was providing incontinent care for the resident. She stated she observed the family member to smack the resident's penis repeatedly, and it made her (CNA #8) feel uncomfortable. CNA #8 revealed she observed the family member forcefully feeding the resident and had obtained a small plastic spoon, forcing the resident to eat. She stated the family member kept a book on everything that went on and made it hard on the CNAs.</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>Interview with CNA #9, on 10/23/15 at 10:45 AM, revealed Resident #1's family member (niece) was at the facility daily, sometimes two (2) or three (3) times a day. CNA #9 revealed his/her niece was present during incontinent care at times, and the family member (niece) "would grab the resident's penis until the resident would void". Additionally, she stated the resident's niece would stick her finger in the resident's rectum, stating she was trying to make the resident's bowels move. CNA #9 revealed she never saw the resident have a bowel movement when the family member did that, and stated the resident would curse the family member. CNA #9 stated it made her feel uncomfortable, so she told a nurse, whom she refused to identify, "that was not right you do not do that to your uncle". CNA #9 stated she "believed it was physical and sexual abuse".</p> <p>Interview with CNA #11, on 10/23/15, revealed Resident #1's family member provided care to the resident daily. CNA #11 stated she has been present at times when the family member provided care and felt the family member "was a little rough in the shower". She stated the resident's family member (niece) would wash the resident with a soapy rag, and it looked like she would stick her whole hand up in the resident's rectum and he/she cursed her. She stated the resident's niece would "shove" food in his/her mouth with her hand. CNA #11 stated they all discussed how rough the family member was with Resident #1; however, she was unaware of any plan to address the issue.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/22/15 at 2:35 PM, revealed the resident's family member (niece) was "very demanding" and</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>provided Resident #1's care on occasion. LPN #1 stated the resident's niece would have CNAs give a second shower during the day. The LPN stated Resident #1's niece was present in the facility every morning and every evening; however, she never received any reports of any "odd" behavior about the family member.</p> <p>Interview with Registered Nurse (RN) #1, on 10/22/15 at 3:30 PM, revealed Resident #1's family member (niece) was loud, and the whole atmosphere would change when she was present. She stated she would change the resident's bed after staff had just changed it, stating her way was the right way. RN #1 did not recall any reports from staff about the family member being too rough with the resident's care.</p> <p>Interview with RN #3, on 10/23/15 at 7:35 AM, revealed Resident #1's family member was at the facility daily and did provide resident care. RN #3 stated she had not been present when the family member provided care; however, she stated she has heard the resident yell out when the family member was providing care or getting the resident out of bed. RN #3 revealed no one had reported an allegation against Resident #1's family member (niece).</p> <p>Interview with the facility's Cook, on 10/22/15 at 3:05 PM, revealed, that recently on the weekend, Resident #1's family member had asked for a trash bag and placed the resident's meal into the trash bag, to include the dishes, and took it to her car. The Cook revealed she knew the resident's family member was "mad" by the expression on her face, and stated the resident's family member continuously wrote in a book. The Cook stated the resident's family member returned the</p>	F 223			

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F 223	<p>Continued From page 10 facility's dishes the following Monday.</p> <p>Interview with the Business Office Manager (BOM), on 10/22/15 at 3:55 PM, revealed Resident #1's family member (niece) was at the facility daily and her behaviors were "bizarre and recently worse". She stated it was "like something switched, she was being loud, very disruptive, and there was something in her eyes".</p> <p>Further interview with the DON, on 10/23/15 at 12:15 PM, revealed she was aware of Resident #1's family member (niece) sticking her fingers in the resident's rectum and provided education to the resident's family member on 08/28/15. A CNA had reported to her but she could not recall which CNA. The DON also stated she was aware of the family member insisting on multiple baths, and she had arranged for the resident to have showers/baths at a time when the family member could be there to prevent an additional bath or shower. The DON stated she monitored the family member's behavior by telling staff to monitor, and she would personally knock on the door when the family member was in the room with the resident. Additionally, the DON stated the family member voiced understanding about not sticking her fingers in the resident's rectum. The DON revealed "staff were aware per conversation that she (resident's niece) was not to do that".</p> <p>Interview with the Administrator, on 10/23/15 at 12:50 PM, revealed when she first came to the facility in February 2015, she recalled a discussion about Resident #1's family member (niece) removing feces from the resident's rectum. She revealed she did not have a concern with Resident #1's family member providing care</p>	F 223			

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F 223	Continued From page 11 until she viewed the 10/03/15 video of the meal, on 10/05/15. She revealed she became aware when the interviews with staff were conducted during the investigation, initiated on 10/05/15.	F 223			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the the facility policy for abuse/neglect was implemented for one (1) resident, in the selected sample of four (4) residents (Resident #1). Resident #1, who required extensive assistance for all activities of daily living (ADLs), had a family member (niece) present daily who provided care. Review of a surveillance video revealed the family member holding the resident's arms and force feeding the resident several bites of food. Additionally, when the resident became combative, kicking at the family member and moving the wheelchair backward, the family member was observed to grab the wheelchair pulling it back under the table with enough force to cause the resident's body to to move backward and then forward. The facility Administrator notified the police to ensure the family member did not return to the facility and initiated an investigation to include obtaining staff statements. The staff statements revealed the	F 226 <u>F226</u> <u>Residents affected</u> 1. Resident #1 was immediately kept from niece. Administrator called Bowling Green Police on 10/5/15 after viewing video from 10/3/15 allowing police to ban niece and keep her from returning to facility. Resident #1 was assessed by ADON, Police officer and clinical supervisor on 10/5/15 with no areas noted. Resident was monitored for changes in condition by nursing daily for 2 weeks by ADON, DON and/or charge nurse. Picture of family member placed at time clock with instructions on calling police immediately then Administrator if she returns to the facility by the Administrator on 10/5/15. For one week this information on niece was passed in the 24 hour nursing report stating to call the police if she attempted	11-2-15 <i>[Signature]</i>		

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F 226	<p>Continued From page 12</p> <p>family member had been too rough with care, had been forcing the resident to urinate before she would leave for the day and would stick her fingers in the resident's rectum to check for stool and cleanliness.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Care Plans Administrative Policies" (Revised January 2002), revealed:</p> <ol style="list-style-type: none"> Care plan goals and objectives are defined as the desired outcome for a specific resident problem. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives were established. Care plans will be modified accordingly. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and a) are resident oriented; b) are behaviorally stated; c) are measurable; and d) contain timetables to meet the resident's needs in accordance with the comprehensive assessment. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. Goals and objectives are reviewed and/or revised a) when there has been a significant change in the resident's condition; b) when the desired outcome has not been achieved; c) when the resident has been readmitted to the facility from a hospital/rehabilitation stay; and d) at least quarterly. The resident has the right to refuse to 	F 226	<p>to return to the facility starting 10/5/15. All staff was educated on contacting police immediately if niece returned to the facility and then to call facility Administrator by DON, ADON and Administrator starting on 10/5/15 and completed on 10/23/15.</p> <p><u>Residents Potentially Affected</u></p> <ol style="list-style-type: none"> No Residents were identified with family members providing their ADL care by Social Worker, ADON, DON and/or Administrator on 11/18/15. 100% of all residents were interviewed to identify any abuse and/or neglect that had not been reported by Social Services and Admissions on 11/19/15. <p><u>Measures/Systematic Changes</u></p> <ol style="list-style-type: none"> All staff have been reeducated on importance of reporting abuse or neglect to immediate supervisor and to the abuse coordinator, the Administrator, the abuse and neglect policy which includes intervening immediately by removing 	11/27/15 BT	

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F 226	<p>Continued From page 13</p> <p>participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.</p> <p>Review of the facility training (Silverchair Learning), revealed "Resident abuse can occur at any time and in any location. The disturbing thing about resident abuse is that it is usually committed by someone who is trusted by the resident. Facility employees, friends of a resident, and even resident family members may abuse a resident."</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses to include Peripheral Vascular Disease (PVD), Dementia without Behavioral Disturbance, Major Depressive Disorder, Muscle Weakness, Hypertension (HTN), Constipation, Diabetes Mellitus (DM) with Polyneuropathy, and Above the Knee Amputation (AKA). Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/04/15, revealed the facility determined the resident was cognitively impaired with a Brief Interview Mental Status score of four (4). He/she was not interviewable and required extensive assistance with all activities of daily living (ADLs).</p> <p>Review of the facility's investigation, dated 10/08/15, revealed Resident #1's niece presented a nine (9) page hand written document to the Administrator on 10/05/15, which contained a time line of staff's actions in the facility's dining room during a meal service on 10/03/15. Additionally, she presented plates of food she had taken out of the facility. The resident's niece alleged that staff did not attempt to feed the</p>	F 226	<p>resident from situation and if there were any current concerns to report, and the ban on the niece of Resident #1 and to contact police immediately if she comes to the facility given by the Administrator on 10/30/15. Staff will be unable to work until completing the education on 11/21/15 if missed on 10/30/15.</p> <p>2. Staff Educated to report any family members requesting to give care to the resident to DON, ADON and/or Administrator on 11/21/15 by Administrator. Staff will be unable to work until completing the education on 11/21/15.</p> <p>3. Family members identified to be requesting to give care to the resident will have staff member present during care and will be placed on ADL care plan by licensed nurse that family member assist with their care.</p> <p><u>Monitoring Changes</u></p> <p>1. New Staff to be educated on abuse and neglect policy during orientation. All staff to be educated twice yearly on abuse</p>	11-21-15 J	

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F 226	<p>Continued From page 14</p> <p>resident for a long enough period of time. Further review of the investigation revealed the Administrator viewed the video surveillance recording of the meal. The Administrator was unable to verify the accuracy of the time line of staff actions presented by the resident's niece. Review of the recording revealed the resident's niece going in and out of the dining room, and at one (1) point, took Resident #1's plate of food, placing the plate of food in a bag, and leaving the building with the bag. Within a few minutes, she returned and had the kitchen prepare another tray. She sat beside Resident #1 and wrote information on a tablet until all but one (1) resident left the dining room, at which time she held Resident #1's arms down and pushed the spoon of food into the resident's mouth. The resident kicked and hit at his/her niece causing his/her wheelchair to roll backward. She then grabbed the wheelchair and pulled the resident back to the table with enough force that his/her body moved backward in the wheelchair, and then forward. She continued to force feed the resident four (4) to five (5) more times. She then took the food tray to the resident's room and came back to get the resident.</p> <p>Further review revealed the Administrator obtained staff statements and notified the police to ensure the resident's niece did not return to the facility. The police viewed the video recording, and were aware of staff's statements alleging the resident's niece force fed the resident, about the niece being rough with the resident's penis during incontinent care, and about the niece sticking her fingers in the resident's rectum checking for stool. Interview with the Police Officer revealed he located the niece and she was legally banned from the facility for two (2) years.</p>	F 226	<p>and neglect policy and as needed for updates to policy. Administrator to audit abuse and neglect policy training and Speak with 10 residents to ensure any abuse or neglect has been reported monthly times (3) three months and quarterly times (1) one quarter to ascertain that facility is educating on abuse and neglect policy.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, Pharmacy, Social Services, Medical Director, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>		

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F 226	Continued From page 15 Interview with the Director of Nursing (DON), on 10/22/15 at 8:45 AM, revealed Resident #1's family member was at the facility daily and provided care for Resident #1. She stated the family member spent a half hour or so a day talking to the Administrator, and expressed her dissatisfaction with the care provided by the facility staff. The DON revealed that, at times, the family member's discussions would be personal and not about the resident. She revealed the family member had "always been intense" and had recently taken a urine soaked brief to a facility employee's house to show the employee, and all the while blocking a lane of traffic, and did the same with a grilled cheese sandwich. The DON stated the family member was very intense and "bizarre", and had been in a "manic state" the last couple of weeks, and was also taking notes about activities of staff. Interview with Certified Nurse Aide (CNA) #1, on 10/22/15 at 11:00 AM, revealed Resident #1's family member came to the facility two (2) times daily and provided care for Resident #1. The CNA revealed the resident's family member would shower the resident, after the staff had already showered the resident, and would tell the staff she felt the resident was not clean enough. CNA #1 stated the resident's family member provided incontinent care and put a clean incontinent brief on the resident "very tightly" so urine would not leak out. CNA #1 also stated the last couple of weeks the family member got rough during care, and it was like "she was trying to scrub his/her skin off". CNA #1 revealed the family member had been forceful while feeding the resident even after the resident would say he/she did not want anything. CNA #1 stated "we said something to	F 226			

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F 226	<p>Continued From page 16</p> <p>the Administrator" and were told she would speak to the resident's family member.</p> <p>Interview with CNA #2, on 10/22/15 at 11:30 AM, revealed Resident #1's family member would provide care for the resident for an hour, and then spend four (4) hours watching staff. CNA #2 stated one (1) day recently, the family member "acted like the world had ended because Resident #1 was the last resident to be taken to the dining room". The CNA stated the resident's family member kept documenting in a book and asking staff names. CNA #2 stated "it was like something changed and she snapped this last weekend". CNA #2 revealed the family member had followed staff to the smoking area outside the facility demanding the CNAs return inside the facility and transfer Resident #1 for her.</p> <p>Interview with CNA #3, on 10/22/15 at 2:05 PM, revealed Resident #1's family member always insisted on a second bath or shower for Resident #1, and the resident would "cuss" the family member. CNA #3 revealed the resident's family member would take fingers full of food and place in the resident's mouth and try to make him/her eat the food. Additionally, the CNA revealed Resident #1's family member "put Vaseline in the resident's butt to clean him/her out". CNA #3 stated the resident's niece was angry with staff all the time and told staff she was going to bring her lawyer to the facility. CNA #3 stated she told a nurse; however, did not recall who she told, about three (3) days before the resident's niece was banned from the facility. CNA #3 stated she felt the family member was trying hard to care for the resident, but seemed to be "overwhelmed" trying to take care of him/her.</p>	F 226			

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F 226	<p>Continued From page 17</p> <p>Interview with CNA #4, on 10/22/15 at 2:20 PM, revealed Resident #1 was usually cooperative with care unless the resident's family member was present. She stated "the family member showered the resident even though the resident already had a shower", and insisted on providing the resident's care; however, she would "put the call light on for staff to come and transfer him/her". The CNA stated the resident would get "mad and agitated" after the family member provided care. CNA #4 revealed the resident's family member spoke about Resident #1 being constipated and would want medicine administered to him/her.</p> <p>Interview with CNA #5, on 10/22/15 at 3:20 PM, revealed Resident #1 was usually cooperative with care unless the resident's family member (niece) was present. She stated the resident would yell at his/her niece during care, as she was providing the care. CNA #5 revealed Resident #1 was pleasant and ate if he/she was hungry; however, the resident's niece sometimes became upset with staff, stating the resident needed "more". CNA #5 stated the resident's niece "would go up the rectum" when she provided incontinent care, and Resident #1 would state "tell her to quit" and cuss her. Additionally, CNA #5 stated "they (someone in Administration) would talk to the niece, and she would get better; however, she would go back to it". She revealed when Resident #1 would say he/she "was done" during a meal while his/her niece was feeding him/her, the niece tried to keep feeding him/her, and the resident would get upset.</p> <p>Interview with CNA #6, on 10/22/15 at 4:15 PM, revealed Resident #1's niece was loud at times and demanded staff's presence. CNA #6</p>	F 226			

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F 226	<p>Continued From page 18</p> <p>revealed the resident's niece had been to the Administrator saying "the staff did not do this or that", but she has never been reprimanded for anything. CNA #6 stated the resident's niece wanted the incontinent brief "very snug" and would put Vaseline on the resident from head to toe.</p> <p>Interview with CNA #7, on 10/23/15 at 7:45 AM, revealed she could not recall a day when Resident #1's niece was not at the facility. She stated the resident's niece expected the staff to "drop everything" when she walked in the door. CNA #7 revealed the resident's niece would go from resident room to resident room, opening the door looking for staff. CNA #7 revealed the family member (niece) had recently been worse by dumping the resident's food in a bag and putting the bag in her car. CNA #7 recalled a time when the family member was in the resident's dining room and snapped her fingers stating "don't make the nig**r in me come out". CNA #7 stated it made her uncomfortable and was concerned about other residents present in the dining room.</p> <p>Interview with CNA #8, on 10/23/15 at 10:20 AM, revealed she was present when Resident #1's family member (niece) was providing incontinent care for the resident. She stated she observed the family member to smack the resident's penis repeatedly, and it made her (CNA #8) feel uncomfortable. CNA #8 revealed she observed the family member forcefully feeding the resident and had obtained a small plastic spoon, forcing the resident to eat. She stated the family member kept a book on everything that went on and made it hard on the CNAs.</p> <p>Interview with CNA #9, on 10/23/15 at 10:45 AM,</p>	F 226			

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F 226	<p>Continued From page 19</p> <p>revealed Resident #1's family member (niece) was at the facility daily, sometimes two (2) or three (3) times a day. CNA #9 revealed his/her niece was present during incontinent care at times, and the family member (niece) "would grab the resident's penis until the resident would void". Additionally, she stated the resident's niece would stick her finger in the resident's rectum, stating she was trying to make the resident's bowels move. CNA #9 revealed she never saw the resident have a bowel movement when the family member did that, and stated the resident would curse the family member. CNA #9 stated it made her feel uncomfortable, so she told a nurse, whom she refused to identify, "that was not right you do not do that to your uncle". CNA #9 stated she "believed it was physical and sexual abuse".</p> <p>Interview with CNA #11, on 10/23/15, revealed Resident #1's family member provided care to the resident daily. CNA #11 stated she has been present at times when the family member provided care and felt the family member "was a little rough in the shower". She stated the resident's family member (niece) would wash the resident with a soapy rag, and it looked like she would stick her whole hand up in the resident's rectum and he/she cursed her. She stated the resident's niece would "shove" food in his/her mouth with her hand. CNA #11 stated they all discussed how rough the family member was with Resident #1; however, she was unaware of any plan to address the issue.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 10/22/15 at 2:35 PM, revealed the resident's family member (niece) was "very demanding" and provided Resident #1's care on occasion. LPN #1 stated the resident's niece would have CNAs</p>	F 226			

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F 226	<p>Continued From page 20</p> <p>give a second shower during the day. The LPN stated Resident #1's niece was present in the facility every morning and every evening; however, she never received any reports of any "odd" behavior about the family member.</p> <p>Interview with Registered Nurse (RN) #1, on 10/22/15 at 3:30 PM, revealed Resident #1's family member (niece) was loud, and the whole atmosphere would change when she was present. She stated she would change the resident's bed after staff had just changed it, stating her way was the right way. RN #1 did not recall any reports from staff about the family member being too rough with the resident's care.</p> <p>Interview with RN #3, on 10/23/15 at 7:35 AM, revealed Resident #1's family member was at the facility daily and did provide resident care. RN #3 stated she had not been present when the family member provided care; however, she stated she has heard the resident yell out when the family member was providing care or getting the resident out of bed. RN #3 revealed no one had reported an allegation against Resident #1's family member (niece).</p> <p>Interview with the facility's Cook, on 10/22/15 at 3:05 PM, revealed, that recently on the weekend, Resident #1's family member had asked for a trash bag and placed the resident's meal into the trash bag, to include the dishes, and took it to her car. The Cook revealed she knew the resident's family member was "mad" by the expression on her face, and stated the resident's family member continuously wrote in a book. The Cook stated the resident's family member returned the facility's dishes the following Monday.</p>	F 226		
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F 226	<p>Continued From page 21</p> <p>Interview with the Business Office Manager (BOM), on 10/22/15 at 3:55 PM, revealed Resident #1's family member (niece) was at the facility daily and her behaviors were "bizarre and recently worse". She stated it was "like something switched, she was being loud, very disruptive, and there was something in her eyes".</p> <p>Further interview with the DON, on 10/23/15 at 12:15 PM, revealed she was aware of Resident #1's family member (niece) sticking her fingers in the resident's rectum and provided education to the resident's family member on 08/26/15. A CNA had reported to her but she could not recall which CNA. The DON also stated she was aware of the family member insisting on multiple baths, and she had arranged for the resident to have showers/baths at a time when the family member could be there to prevent an additional bath or shower. The DON stated she monitored the family member's behavior by telling staff to monitor, and she would personally knock on the door when the family member was in the room with the resident. Additionally, the DON stated the family member voiced understanding about not sticking her fingers in the resident's rectum. The DON revealed "staff were aware per conversation that she (resident's niece) was not to do that".</p> <p>Interview with the Administrator, on 10/23/15 at 12:50 PM, revealed when she first came to the facility in February 2015, she recalled a discussion about Resident #1's family member (niece) removing feces from the resident's rectum. She revealed she did not have a concern with Resident #1's family member providing care until she viewed the 10/03/15 video of the meal, on 10/05/15. She revealed she became aware</p>	F 226		
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F 226	Continued From page 22	F 226			
F 280 SS=D	when the interviews with staff were conducted during the investigation, initiated on 10/05/15. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the care plan for one (1) resident, in the selected sample of four (4) residents (Resident #1), was reviewed and revised to address a family member who was banned from the facility to prevent him/her from providing care for the resident.	F 280	<u>F280</u> <u>Residents affected</u> 1. Resident # 1 care plan was updated by MDS Director to reflect that resident's niece was banned from the facility and this prevented niece from providing care for him on 10/23/15. <u>Residents Potentially Affected</u> 1. Residents with family members providing their care have the potential to be affected by the alleged deficient practice. <u>Measures/Systematic Changes</u> 1. 100% of ADL care plans audited by DON, MDS and/or ADON for ADL care plan accuracy on 11/13/15. 2. Re educated all licensed nurses on care plan policy and ADL care plans reflecting care being given to the resident on	11/27/15 <i>[Signature]</i>	

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F 280	Continued From page 23 The findings include: Review of the facility's policy/procedure, "Care Plans Administrative Policies" (Revised January 2002), revealed: 1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem. 2. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives were established. Care plans will be modified accordingly. 3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and a) are resident oriented; b) are behaviorally stated; c) are measurable; and d) contain timetables to meet the resident's needs in accordance with the comprehensive assessment. 4. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. 5. Goals and objectives are reviewed and/or revised a) when there has been a significant change in the resident's condition; b) when the desired outcome has not been achieved; c) when the resident has been readmitted to the facility from a hospital/rehabilitation stay; and d) at least quarterly. 6. The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies.	F 280	11/20/15 by ADON, MDS and/or DON. New hire licensed nurses will be educated on the care planning process during their orientation by the licensed nurse. Staff will be unable to work until completing the education on 11/20/15 if missed on 11/20/15. <u>Monitoring Changes</u> 1. DON, MDS and/or ADON to audit 2 ADL care plans weekly times (1) one month and monthly times (3) months to ascertain that ADL care plans are accurate per care plan policy. The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, Pharmacy, Social Services, Medical Director, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.	11-21-15 Q	

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F 280	Continued From page 24 Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses to include Peripheral Vascular Disease (PVD), Dementia without Behavioral Disturbance, Major Depressive Disorder, Muscle Weakness, Hypertension (HTN), Constipation, Diabetes Mellitus (DM) with Polyneuropathy, and Above the Knee Amputation (AKA). Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/04/15, revealed the facility determined the resident was cognitively impaired with a Brief Interview Mental Status score of four (4). He/she was not interviewable and required extensive assistance with all activities of daily living (ADLs). Review of the facility's investigation, dated 10/08/15, revealed Resident #1's niece presented a nine (9) page hand written document to the Administrator on 10/05/15, which contained a time line of staff's actions in the facility's dining room during a meal service on 10/03/15. Additionally, she presented plates of food she had taken out of the facility. The resident's niece alleged that staff did not attempt to feed the resident for a long enough period of time. Further review of the investigation revealed the Administrator viewed the video surveillance recording of the meal. The Administrator was unable to verify the accuracy of the time line of staff actions presented by the resident's niece. Review of the recording revealed the resident's niece going in and out of the dining room, and at one (1) point, took Resident #1's plate of food, placing the plate of food in a bag, and leaving the building with the bag. Within a few minutes, she returned and had the kitchen prepare another tray. She sat beside Resident #1 and wrote information on a tablet until all but one (1)	F 280			

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F 280	<p>Continued From page 25</p> <p>resident left the dining room, at which time she held Resident #1's arms down and pushed the spoon of food into the resident's mouth. The resident kicked and hit at his/her niece causing his/her wheelchair to roll backward. She then grabbed the wheelchair and pulled the resident back to the table with enough force that his/her body moved backward in the wheelchair, and then forward. She continued to force feed the resident four (4) to five (5) more times. She then took the food tray to the resident's room and came back to get the resident.</p> <p>Further review revealed the Administrator obtained staff statements and notified the police to ensure the resident's niece did not return to the facility. The police viewed the video recording, and were aware of staff's statements alleging the resident's niece force fed the resident, about the niece being rough with the resident's penis during incontinent care, and about the niece sticking her fingers in the resident's rectum checking for stool. Interview with the Police Officer revealed he located the niece and she was legally banned from the facility for two (2) years.</p> <p>Review of Resident #1's care plans, dated 07/15/15, revealed there was no revision intervention specific to addressing the banned presence of a family member or what to do if she appeared until 10/26/15.</p> <p>Interview with the Director of Nursing (DON), on 10/26/15 at 4:00 PM revealed Resident #1's care plan did not address the niece providing personal care until 10/23/15. Additionally, the care plan was not revised to reflect the niece not coming in the facility or what to do if she did until 10/26/15. The DON felt, however, staff were aware of what</p>	F 280			

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F 280	Continued From page 26 to do.	F 280			