

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

PRINTED: 11/13/2012
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(IX2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(IX3) DATE SURVEY COMPLETED C 10/26/2012
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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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(IX4) ID PREFIX TAG	SUMMARY STATEMENT (IF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(II) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(IX5) COMPLETION DATE
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F 000 INITIAL COMMENTS

An Abbreviated/Partial Extended Survey Investigating KY#00019138 and KY#00019228 was conducted 10/12/12 through 10/26/12. KY#00019138 was unsubstantiated with no deficiencies and KY#00019228 was substantiated with deficiencies cited at Immediate Jeopardy.

The facility's Administration failed to have an effective system to ensure policy and procedures were implemented to protect residents from abuse; failed to ensure staff was knowledgeable of the facility's policy and procedures related to abuse; and, failed to ensure information made available to staff regarding abuse was accurate. On 10/04/12 three staff witnessed State Registered Nursing Assistant (SRNA) #2 verbally and/or physically abuse five residents (Residents #2, #3, #4, #5, and #6). Staff failed to report this abuse immediately and the alleged perpetrator continued to provide resident care for approximately fourteen and a half hours after the first alleged abusive incident was witnessed. Staff interviews revealed they thought they had twenty-four hours to report an allegation of abuse.

Immediate Jeopardy was identified on 10/10/12 and determined to exist on 10/04/12, at 42 CFR 483.13 Resident Behavior and Facility Practice, F-224 and F-226 at a Scope and Severity (S/S) of a "J"; and 42 CFR 483.75 Administration, F-490 at a S/S of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behavior and Facility Practice.

An acceptable credible Allegation of Compliance (A/C) was received on 10/23/12 and alleged the immediate Jeopardy was removed on 10/21/12.

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The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, Wurland Nursing and Rehabilitation Center (WNRC) has taken or will take the following actions.

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It is the policy of Wurland Nursing and Rehabilitation Center that all residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion as specified in 483.13.

SRNA #2 was immediately suspended from work by the Director of Nursing (registered nurse) on 10/5/12 until her eventual termination by the Director of Nursing (registered nurse) on 10/18/12. SRNA #3, #4, and #6 were given disciplinary actions and education by the Director of Nursing

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

TITLE

(IX6) DATE

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

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F 000 Continued From page 1
The State Survey Agency verified the Immediate Jeopardy was removed on 10/21/12 as alleged prior to exit on 10/26/12. The Scope and Severity of the immediate Jeopardy deficiencies at a "J" was lowered to a "D" while the facility develops, implements, and monitors a Plan of Correction to prevent recurrence of the deficient practice.

An additional deficiency was cited during the abbreviated survey at 42 CFR 483.20 Resident Assessment, F-250, at a S/S of a "D".

F 223 483.13(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 it was determined the facility failed to have an effective system to ensure residents were free from abuse. The facility failed to ensure staff reported allegations of abuse immediately and failed to ensure residents were protected from further abuse by allowing the alleged perpetrator to continue to provide resident care. On 10/04/12, three (3) eyewitnesses (State Registered Nursing Assistants #3, #4, and #6) observed State Registered Nursing Assistant (SRNA) #2 cursing at five (5) separate residents (Residents #2, #3, #4, #5, and #6) and being

F 000 (registered nurse) regarding reporting requirements prior to returning to work.

Residents #2, #3, #4, #5, and #6 identified as having been allegedly mistreated were not interviewable. Pain assessments and skin assessments were completed on 10/5/12 by the MDS Coordinator (registered nurse), RN Supervisor (registered nurse) and Assistant Director of Nursing (registered nurse) for the 5 residents who were identified with no issues noted. The Medical Director was notified regarding each of these five residents on 10/5/12 with no new orders received. All responsible parties were notified, with the exception of one responsible party who has continued to be unavailable to our phone calls. A letter was sent on 10/20/12 asking this responsible party to call the facility as we were unable to contact them despite many attempts. The responsible parties who were contacted were interviewed by the Director of

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F 223: Continued From page 2
physically abusive to two (2) of the five (5) residents (Residents #2 and #3) from approximately 7:30 AM until after the evening meal on 10/04/12. SRNA #4 witnessed SRNA #2 curse at Resident #5 and observed her to jerk on the resident. SRNA #6 witnessed SRNA #2 curse at Resident #2 and observed her to open handedly slap the resident on the shoulder leaving a red mark. SRNA #3 witnessed SRNA #2 curse at Residents #3, #4, and #6, and observed SRNA #2 smack Resident #3's hand "a few times". However the three (3) eyewitnesses failed to notify a Supervisor of the abusive incidents immediately as per facility policy. This allowed SRNA #2 to continue providing care to other residents on 10/04/12 until her shift ended at 9:59 PM, which was approximately fourteen and a half (14 1/2) hours after the first alleged abusive incident.

The facility's failure to ensure residents were free from abuse placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 10/19/12 and was determined to exist on 10/04/12. The facility was notified of the Immediate Jeopardy on 10/19/12. Substandard Quality of Care (SQC) was identified at 42 CFR 483.13, Resident Behavior and Facility Practice.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 10/23/12 with the facility alleging removal of the Immediate Jeopardy on 10/21/12. The State Survey Agency verified removal of Immediate Jeopardy as alleged in the acceptable AoC on 10/21/12 prior to exiting the facility on 10/26/12. However, non-compliance continued to exist at 42 CFR

F 223
Nursing on 10/5/12. None of the families indicated any change in resident behavior but were encouraged to contact the Director of Nursing with any changes or information.

All residents in the facility underwent skin assessments on 10/5/12 by 3 MDS Coordinators (2 registered nurses and 1 licensed practical nurse), RN Supervisor (registered nurse) Assistant Director of Nursing (registered nurse), and Staff Development Coordinator (registered nurse) with no issues noted. All interviewable residents on the unit where the SRNA was permanently assigned (front hall) were interviewed by the Assistant Director of Nursing (a registered nurse) and the Registered Nurse/MDS Coordinator on 10/05/12. All interviewable residents in the remaining unit (back hall) were interviewed by the Director of Nursing (a registered nurse) and the Assistant Director of Nursing (a registered nurse) on 10/20/12. All residents

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F 223	Continued From page 3 483.13 Resident Behavior and Facility Practice, with a S/S of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure residents remain free from abuse. The findings include: Review of the facility's policy titled, "Abuse, Neglect, and Exploitation", dated 07/01/09 revealed when abuse, mistreatment, exploitation, or neglect was suspected, the person who suspected abuse would immediately notify the Supervisor. The Supervisor would notify the Administrator or Director of Nursing (DON), who would complete an incident report immediately and initiate an investigation. Review of the written statement obtained by the DON on 10/05/12, from SRNA #10 revealed three (3) aides had come to her about SRNA #2 being abusive. She documented SRNA #4 reported to her that SRNA #2 had jerked on Resident #5 and the resident had told her (SRNA #2) to stop jerking him/her. SRNA #2 "cussed" him/her and yelled at him/her for not helping them. SRNA #10 documented SRNA #2 called Resident #5 a "fucking dumbass". Continued review of the statement revealed SRNA #3 had told her that while working the evening shift on 10/04/12, SRNA #2 had cursed at Resident #4 and was too rough with the resident. Then when they (SRNA #3 and SRNA #2) went to Resident #6's room SRNA #2 was screaming and cursing at the resident so loudly that SRNA #7/Certified Medication Technician (CMT) came in and told	F 223	were asked if they had ever experienced any form of mistreatment in this facility. No resident reported any form of mistreatment. During the interviews, these residents were also encouraged to voice any concerns now and ongoing with no concerns noted at this time. A Brief Interview for Mental Status (BIMS-Section C on MDS) was completed for the non-interviewable residents on the unit where the SRNA was permanently assigned (front hall) by the MDS Coordinator (a registered nurse) on 10/19/12 and showed no declines from previous BIMS scores. All facility staff (this includes all disciplines, departments, and shifts) received additional education regarding Abuse, neglect, exploitation, resident rights and allegation reporting from 10/5/12-10/11/12 by Staff Development Coordinator (registered nurse). This education was derived from the correct		

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F 223 Continued from page 4

her to stop. SRNA #10 documented SRNA #3 told her that when Resident #3 was being combative, SRNA #2 had "smacked" Resident #3 on the arm and "cussed and yelled" at him/her. Further review of the written statement revealed SRNA #10 documented at 11:30 PM on 10/04/12, SRNA #8 had telephoned her and told her SRNA #2 had been abusive and he wanted to know what to do about it. SRNA #10 documented SRNA #6 and SRNA #2 had been caring for Resident #2 when he/she became combative. SRNA #10 documented SRNA #2 cursed at Resident #2 and "smacked" him/her "so hard it left a red mark...". SRNA #10 documented she had informed all three (3) of the SRNAs who had witnessed the abusive incidents to "come forward" and tell.

1. Review of Resident #5's medical record revealed the facility readmitted the resident on 09/20/12 with diagnoses which included Renal Failure and right above the knee Amputation. Review of the Significant Change Minimum Data Set (MDS), dated 09/28/12, revealed the facility assessed Resident #5 to have Brief Interview of Mental Status (BIMS) score of nine (9) out of fifteen (15), which indicated the resident was moderately impaired with daily decision making. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance with his/her Activities of Daily Living (ADLs).

Review of the written statement obtained by the DON on 10/05/12 during the abuse investigation, SRNA #4 revealed on 10/04/12 at approximately 7:30 AM, she observed SRNA #2 jerking Resident #5's brief up, and heard Resident #5 tell

F 223

policies.

The Administrator, Director of Nursing (a registered nurse) and Regional Continuous Quality Improvement Director (registered nurse) reviewed the Facility Abuse Policy provided to the surveyor on 10/19/12. It was noted that the policy provided to the surveyor was not the current policy regarding Abuse, Neglect and Exploitation. The current policy states in part, "When abuse, mistreatment, exploitation or neglect is suspected, the person who suspects the abuse will immediately (as soon as you see it or suspect it and resident safety has been secured) notify the supervisor." These policies have been developed and implemented in order to prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. On 10/19/12, the Regional Continuous Quality Improvement Director (registered nurse) provided additional education to the Administrator related to the current Resident

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F 223. Continued From page 5
SRNA #2 to stop jerking him/her around. SRNA #4 heard SRNA #2 raise her voice and state to Resident #5 that he/she had to "fucking help you dumbass". SRNA #4 continued to observe SRNA #2 jerking on Resident #5. Resident #5 told SRNA #2 she was being rough. When SRNA #2 and SRNA #4 assisted Resident #5 into the wheelchair, SRNA #2 was screaming, "fucking help, (Resident #5) gentleman". SRNA #4 placed Resident #5's hat on the resident's head and SRNA #2 jerked it off his/her head and "slung it across the room". SRNA #2 told the resident he/she needed to start helping or they were going to have broken backs and end up in bed like him/her, and they weren't going to get him/her out of bed anymore. SRNA #2 stated to the resident, "...this is fucking ridiculous" and left the room.

Interview, on 10/17/12 at 11:20 AM, with SRNA #4 revealed she confirmed the incidents of abuse in her written statement. She stated she did not report the abusive incident to the nurses as there was a "bunch of people" at the nurse's station and she didn't want to say anything in front of everybody. SRNA #4 stated she usually worked the 10:00 PM to 6:00 AM shift; however, on 10/04/12 had stayed over to help out on day shift for a while. The SRNA stated she told SRNA #10 about the abusive incident when she got off work the morning of 10/04/12. She stated SRNA #10 informed her she needed to report the abuse. According to the SRNA, she was going to call the DON about the abusive incidents; however, did not have her telephone number. SRNA #4 stated when she went to work at 10:00 PM on 10/04/12, she reported the abusive incidents to Licensed Practical Nurse (LPN) #3 and Registered Nurse (RN) #1. The SRNA stated when she told LPN

F 223
Advocacy Protocols. Special emphasis included the current Abuse Neglect and Exploitation Policy (RAP-IV-003), issued July 1, 2009 by the VP, Quality Management and Clinical Services and VP, Corporate Compliance & Risk Management, which states, in part, that "when abuse, mistreatment, exploitation or neglect is suspected, the person who suspects the abuse will immediately (as soon as you see it or suspect it and resident safety has been secured) notify the Supervisor." Additional education included information related to the current Resident Abuse policy (RAP-IV-001) which states, in part, "the Supervisor shall ensure resident safety and immediately (as soon as it is reported or suspected and resident safety has been secured) notify the Administrator or Director of Nursing."

All facility staff (this includes all disciplines, departments, and shifts) received education regarding Facility Abuse

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F 223	<p>Continued From page 6</p> <p>#3, the LPN informed her she should report the abusive incident to RN #1. SRNA #4 stated she informed RN #1 and he informed her she should report the abuse as soon as possible to the DON, however did not give her a number to do so. She stated she and SRNA #10 reported the abuse at approximately 9:30 AM on 10/05/12 to the Assistant Director of Nursing (ADON). In an additional interview, on 10/17/12 at 6:47 PM, SRNA #4 stated Resident #5 "got really quiet" when SRNA #2 started cursing and jerking at him/her. SRNA #4 stated this was "not like" Resident #5, as he/she usually was talking and "cutting up" with staff. The SRNA stated she thought Resident #5 "fell bad" after SRNA #2 told him/her that he/she was hurting the SRNA's backs.</p> <p>Interview, on 10/18/12 at 2:51 PM, with LPN #3 revealed she worked the 10:00 PM to 6:00 AM shift on 10/04/12. The LPN stated on her shift on 10/04/12, SRNA #4 had reported SRNA #2 had been rough and cursed at a resident earlier that day. She stated she believed what SRNA #4 reported was that SRNA #2 had told a resident to "sit his ass down in the fucking whoel air". LPN #3 stated she immediately told SRNA #4 she had to report the abuse to RN #1 as he was their RN Supervisor. She stated she told SRNA #4 to tell RN #1 "everything she needed to about it" (abusive incident), then RN #1 would decide if he needed to call the DON.</p> <p>Interview, on 10/17/12, with RN #1 revealed he worked the 10:00 PM to 6:00 AM shift. The RN stated SRNA #4 did report the abusive incidents, she had witnessed earlier in the day on 10/04/12, to him. He stated SRNA #4 told him that SRNA</p>	F 223	<p>Protocols by Director of Nursing (a registered nurse) the Assistant Director of Nursing (a registered nurse), and the Staff Development Coordinator (a registered nurse) on 10/19/12 and 10/20/12. This education was all inclusive of the Facility Abuse Policies but special emphasis was placed on Definitions of Abuse, the protection aspect of the policy and the reporting aspect of the policy including the fact of reporting any suspected abuse to your supervisor immediately (as soon as you see it or suspect it and resident safety has been secured). The education further explained that staff are never to use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion and that any violation of this policy would result in corrective action including termination. The definition of immediate was clarified as (as soon as you see it or suspect it and resident safety has been secured).</p>	

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F 223, Continued From page 7
#2 had used profanity towards a resident and she was concerned. He stated he referred her to the DON as he didn't want it to be "gossip" and she wasn't making an official report to him. The RN stated even though SRNA #4 reported the abuse to him, he felt it would be better for her (SRNA #4) to report it as she was the person who had observed it. RN #1 stated he thought the time frame for reporting abuse was twenty-four (24) hours.

Interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed on the morning of 10/04/12 she had picked SRNA #4 up from work after she had stayed over to help out day shift. SRNA #10 stated SRNA #4 was "upset" when she picked her up and told SRNA #10 she didn't know what to do. The SRNA stated SRNA #4 told her that she had witnessed SRNA #2 "jerk" Resident #5 up, and cursing and screaming at him/her. She stated SRNA #4 told her she felt like she needed to talk to the DON or the ADON as she thought she was supposed to report "anything" to them. According to SRNA #10, she told SRNA #4 she needed to report the abuse, however she stated she had always been told they had twenty-four (24) hours to report it if it wasn't something that was "going to be harm". SRNA #10 stated she and SRNA #4 were together all day on 10/04/12 until 4:30 PM, and to her knowledge SRNA #4 had called the DON or ADON on 10/04/12 to report the alleged abuse. SRNA #10 stated she had told SRNA #4 that she would go with SRNA #4 to tell the DON/ADON on 10/05/12. She stated she "honestly" thought SRNA #4 had twenty-four (24) hours to report the abuse.

2. Review of Resident #2's medical record

F 223
The facility has engaged the services of an independent contractor to provide Compassionate and Person Centered Training to the facility's direct care staff and facility administration. The facility does not employ any agency staff. The independent contractor we have retained is:

Barbara W. Stoll, BSW,
MS, ACC
Stoll Health Care
Consulting Services, Inc.
P.O. Box 701934
Saint Cloud, Florida,
34770-1934
stollacc@aol.com
Office: 407-892-9054
Fax: 407-892-1882

The contractor will forward a written report to CMS and the State providing the content of the training, documentation of

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F 223: Continued From page 8

revealed the facility readmitted the resident on 01/27/12 with diagnoses which included Dementia and Anxiety. Review of the Quarterly MDS, dated 08/31/12, revealed the facility assessed Resident #2 to have short term and long term memory problems and was moderately impaired with daily decision making. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance with his/her Activities of Daily Living (ADLs).

Review of the written statement obtained by the DON on 10/05/12, for SRNA #6, revealed at approximately 10:45 AM on 10/04/12, he observed and heard SRNA #2 tell Resident #2 "God xxx xx" and open handedly slapped the resident on the upper left shoulder. SRNA #6 indicated he stopped assisting SRNA #2 as he was speechless.

Interview, on 10/16/12 at 7:20 PM, with SRNA #6 revealed somewhere between 10:00 AM and 12:00 PM, while he and SRNA #2 were assisting Resident #2 with dressing after his/her bath, Resident #2 started "fighting". He stated SRNA #2 said "god damn it" to the resident and then open handedly slapped Resident #2 on his/her left shoulder. According to SRNA #6, the area where SRNA #2 slapped Resident #2 "immediately" started turning red. The SRNA stated he had never witnessed anything like that and didn't know what to do. He stated he "thought if she did this in front of me then what would she do in a room by herself". When asked what the facility policy was on reporting, SRNA #6 indicated he did not remember "the exact timing of reporting". He stated he did tell SRNA #10 that night about the abuse he witnessed.

F 223:

objectives and attendees participating. During the course of the training the independent contractor and governing body (the Director of Nursing, Administrator, Medical Director, Regional Area Administrator, Regional Continuous Quality Improvement Nurse, and Regional Vice President) shall develop a mission statement that reflects a commitment to maintaining and improving quality for Medicare beneficiaries. All training will be completed on or before December 1, 2012.

The independent contractor will evaluate the skills and competency of direct care staff and facility administration on their ability to provide compassionate, person centered care. The contractor shall submit a written report to CMS and the State summarizing the outcomes of the competency skills evaluation of all staff required to take this training. Of particular importance is staff knowledge

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F 223	Continued From page 9 Further interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed at approximately 11:30 PM on 10/04/12, SRNA #6 had telephoned her and reported he had witnessed SRNA #2 being verbally and physically abusive to Resident #2 earlier that day. SRNA #10 stated SRNA #6 informed her that SRNA #2 had jerked on Resident #2 and he/she had started "swatting" at her and SRNA #2 had openly slapped the resident. She stated SRNA #6 felt that he needed to report the abuse, however didn't know what to do. SRNA #10 stated she told SRNA #6 he had to report the abuse and she would go with him to report it the next morning. 3. Review of Resident #4's medical record revealed the facility readmitted the resident on 10/10/09 with diagnoses which included Depression, Anxiety, and history of Cerebrovascular Accident (CVA) with left sided weakness. Review of the Quarterly MDS, dated 08/20/12, revealed the facility assessed Resident #4 to have a BIMS score of eleven (11) out of fifteen (15), which indicated the resident was moderately impaired with daily decision making. Further review of the MDS revealed the facility assessed the resident as requiring limited to extensive assistance with his/her Activities of Daily Living (ADLs). Review of the written statement obtained by the DON on 10/05/12, for SRNA #3 revealed after dinner on 10/04/12, SRNA #3 heard SRNA #2 being verbally abusive to Resident #4, stating "come on (Resident #4), this is the same shit, different day, hush", and was "being excessively rough". The resident was "screaming" telling her	F 223	related to abuse and neglect. This evaluation process will be completed on or before December 1, 2012. The independent contractor will conduct training for the governing body (the Director of Nursing, Administrator, Medical Director, Regional Area Administrator, Regional Continuous Quality Improvement Nurse, and Regional Vice President) and all facility personnel on how to create and maintain a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect. This training will be completed on or before December 1, 2012. The training provided by the independent contractor shall include a discussion of all types of abuse including but not limited to domestic abuse, institutional abuse and neglect, physical abuse, sexual assault, misuse of restraints, chemical restraints, physical restraints, emotional,		

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F 223 Continued From page 10
to stop being so rough, however SRNA #2 continued.

Interview, on 10/12/12 at 4:45 PM, with SRNA #3 revealed on 10/04/12 after dinner she was assisting Resident #4's roommate while SRNA #2 was assisting Resident #4. She stated she heard Resident #4 tell SRNA #2 she was hurting him/her, and pulling on him/her too hard. SRNA #3 stated she asked SRNA #2 if she needed help and SRNA #2 stated "no" she could do the resident herself. SRNA #3 stated she heard SRNA #2 tell Resident #4, "come on (Resident #4), it's the same shit just a different day".

Continued interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed her daughter, SRNA #3 had come home on 10/04/12 at approximately 10:20 PM and told her that she had worked with SRNA #2 that day. She stated SRNA #3 told her SRNA #2 cursed and screamed Resident #4, and the resident had told SRNA #3 that she was hurting him/her.

Interview, on 10/18/12 at 3:20 PM, with Unsampled Resident A, Resident #4's roommate, revealed he/she had observed SRNA #2 being "mean" to Resident #4. He/She stated SRNA #2 "yells" at Resident #4 and was "rough with him/her".

4. Review of Resident #6's medical record revealed the facility readmitted the resident on 06/18/09 with diagnoses which included Alzheimer's Dementia, Psychosis, and Depression. Review of the Annual MDS, dated 09/18/12, revealed the facility assessed Resident #6 to have short term and long term memory

F 223
psychological/verbal abuse, physical neglect, medical neglect, abandonment, and financial or material exploitation.

The facility will provide written information on how to report elder abuse for all employees and facility administration on or before December 1, 2012. The facility does not employ any agency staff. The independent contractor shall also provide information to residents during a resident council meeting on abuse on or before December 1, 2012. A family council meeting will also be conducted by the independent contractor on a weekday (Thursday, November 29, 2012 at 7:00 p.m.) and a weekend (Saturday, December 1, 2012 at 10:00 a.m.) to discuss abuse and reporting with family members. All information regarding how to report abuse will be readily available on request. Training shall include a review of the requirements for reporting reasonable suspicion of a crime in a Long Term Care

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F 223	Continued From page 11 problems and was moderately impaired with daily decision making. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance with his/her Activities of Daily Living (ADLs). Continued review of SRNA #3's written statement, obtained on 10/05/12 by the DON, revealed SRNA #3 and SRNA #2 left Resident #4's room and went to Resident #6's room to assist him/her to bed. SRNA #3 heard SRNA #2 scream at Resident #6 and observed SRNA #2 "roughly" tug on his/her shirt, calling him/her an "old son of a bitch" and telling the resident she was going to "knock" him/her "the fuck out". SRNA #3 intervened and assisted SRNA #2 who kept screaming and cussing. SRNA #7, who was also a Certified Medication Tech (CMT), came in the room and heard SRNA #2 screaming and made the comment she needed to quiet down and SRNA #2 left the room. The SRNA #7/CMT stated to SRNA #3 that SRNA #2 must have been mad at her husband or something; that she was in a bad mood. Interview, on 10/12/12 at 4:45 PM, with SRNA #3 revealed on 10/04/12, SRNA #2 told Resident #6 she was "going to knock him/her the fuck out" and called the resident an old "son of a bitch". She stated SRNA #2 had been "rough" with Resident #6 before and after cursing at the resident. Interview, on 10/16/12 at 7:04 PM, with SRNA #7/CMT revealed on 10/04/12 at "probably past 8:00 PM" SRNA #2 was in Resident #6's room cussing "but not at the resident". He stated SRNA #2 went out into the hallway still cussing	F 223	Facility (LTC) in accordance with S&C: 11-30-NH. CMS and the State survey agency will be provided a signed and notarized attestation statement from the facility administrator verifying training has been provided to all staff on or before December 1, 2012. The facility does not employ any agency staff. During staff interview it was identified that the Elder Abuse federally required posting in the employee break room states that immediate reporting is required but identifies immediate as 2-24 hours. This posting was removed from the breakroom and was posted in an alternate area. This alternate area is by the time clock. The facility continues to meet federally mandated posting requirements as outlined in the Elder Abuse Act. This was identified as a possible root cause of timely reporting and a clear expectation of immediate reporting was included in the staff education provided to all staff		

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F 223 Continued From page 12
and he stated he told her she needed to go take a break. He stated he did not report this to anyone because SRNA #2 was not cussing directly at a resident.

Continued interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed SRNA #3 told her while they, SRNA #3 and SRNA #2, were in Resident #6's room, she had heard SRNA #2 tell the resident she, SRNA #2, was going to "knock him the fuck out". According to SRNA #10, SRNA #3 stated to her that she had observed SRNA #2 jerk Resident #6's clothes off. SRNA #10 stated SRNA #3 informed her that the CMT had heard SRNA #2 as she was being so loud and came into the room and told SRNA #2 she needed to go take a break. She stated SRNA #3 told her that SRNA #2 threw her hands up and stated "fuck it I can't deal with this old son of a bitch".

5. Review of Resident #3's medical record revealed the facility readmitted the resident on 10/12/02 with diagnoses which included Dementia and Senile Psychosis. Review of the Quarterly MDS, dated 09/28/12, revealed the facility assessed Resident #3 to have short term and long term memory problems and was severely impaired with daily decision making. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance to total dependence with his/her Activities of Daily Living (ADLs).

Further review of the written statement, obtained by the DON on 10/05/12 for SRNA #3, revealed as she was assisting SRNA #2 with Resident #3, the resident became combative as they were changing him/her and started smacking SRNA #2

F 223 (this includes all disciplines, departments, and shifts) on 10/19/12 and 10/20/12 in which immediate was clarified (as soon as you see it or suspect it and resident safety has been secured) as explained in the previous paragraph. The facility does not employ any agency staff. This information will be provided to new hires or any staff not included in the above education due to being on leave or unavailable by the Staff Development Coordinator (a registered nurse) or the Assistant Director of Nursing (a registered nurse) prior to assuming any direct care assignment and before returning to work. All staff are re-educated on the abuse policy at a minimum twice a year by the Staff Development Coordinator utilizing Silver Chair, a computerized learning program, created especially for health care industries. Residents and/or the responsible party receive a copy of the facility abuse policy upon admission.

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 on the arms. SRNA #3 observed SRNA #2 smack Resident #3's hands "a few times". SRNA #3 informed SRNA #2 she didn't have to smack Resident #3; to just have the resident hold onto the side rail. SRNA #3 asked Resident #3 to hold onto the side rail which the resident did and Resident #3 was no longer combative. SRNA #2 continued to be rough and used profanity towards Resident #3. SRNA #3 documented she knew she needed to report the abusive incidents she had witnessed SRNA #2 perform. Review of the written statement revealed SRNA #3 informed her mother (SRNA #10) of the abuse and she advised SRNA #3 to go to the DON. However, SRNA #3 documented on 10/05/12 she had to go to class and her mother (SRNA #10) reported the abuse to the DON for her.

Interview, on 10/12/12 at 4:30 PM, with SRNA #3 revealed on 10/04/12 SRNA #2 was being "rough" with Resident #3. She stated Resident #3 exhibited "behavior problems" at times and was also resistant to care. SRNA #3 stated Resident #3 "smacked" SRNA #2 on the hands and SRNA #2 "smacked" the resident back on the hand. Additional interview, on 10/18/12 at 9:00 PM, with SRNA #3 revealed Resident #3 would cooperate with care if he/she was approached calmly. She stated when the resident hit SRNA #2, SRNA #2 hit Resident #3 back. SRNA #3 stated she informed SRNA #2 to stop, she didn't have to do him/her that way. She stated she, SRNA #3, calmed the resident down and then he/she was cooperative with care. SRNA #3 stated she thought she had twenty-four (24) hours to report the abuse because of a poster she had seen in the breakroom. She stated she did not report the abuse to the DON as she wasn't in the facility at

F 223
 The Administrator, Director of Nursing (a registered nurse), Assistant Director of Nursing (a registered nurse) or the Staff Development Coordinator (a registered nurse) will conduct a total of 15 staff interviews per week for 8 weeks regarding the facility's abuse policy and aspects of resident abuse to ensure continued and thorough understanding of the policy. Any incorrect answers will be immediately addressed via 1:1 education. These interviews will be conducted on all shifts and in all departments.

The Administrator, Social Services Director or the Activity Director will conduct Resident Council meetings on a weekly basis for four weeks to determine that residents feel safe in the facility and that the residents are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family members or visitors. Any concerns of this nature will be forwarded to the

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the time, and she didn't have a telephone number at which to phone her, (DON).

Continued interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed SRNA #3 and SRNA #2 went to Resident #3's room and the resident started titling at SRNA #2. She stated SRNA #3 told her SRNA #2 yelled at the resident and took Resident #3's hand and "upon handed slapped it several times". SRNA #10 stated SRNA #3 did not tell anyone, and when asked why, she said that SRNA #2 and the nurse were friends. She stated SRNA #3 felt she needed to report the abuse to the DON or ADON, but there was no way to do so as she didn't have their telephone numbers.

Further interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed at approximately 11:30 AM on 10/05/12, the ADON was notified of the abusive incidents by SRNA #2 that were witnessed by SRNA's #3, #4, and #6. She stated the ADON asked all involved to write out their statements, which they did. SRNA #10 stated the DON told them they should have reported the abuse sooner, however SRNA #10 stated they were still within the twenty-four (24) hour time frame at that time.

Review of the written statement obtained on 10/05/12 by the DON from SRNA #2 revealed SRNA #2 denied being verbally or physically abusive to the five (5) residents involved.

Interview, on 10/14/12 at 12:20 PM, with SRNA #2 revealed she denied being physically or verbally abusive towards any resident.

Review of the facility's time keeping records

F 223 Administrator or DON.

The results of the Resident Council meetings and staff interviews will be discussed weekly in the facility Focus Interdisciplinary Team Meeting. This Focus Interdisciplinary Meeting meets every Thursday and is a sub-committee of the facility's Continuous Quality Improvement Committee. The members of this team include the Administrator, DON (a registered nurse), ADON (a registered nurse), MDS Coordinators (2 registered nurses and a licensed practical nurse), Staff Development Coordinator (a registered nurse), Medical Records Director, Activity Director and Social Services Director. The results will also be followed monthly in the facility Continuous Quality Improvement Committee (CQI) meeting which is held the second Wednesday of every month and consists of the above team members plus Housekeeping/Laundry Supervisor, and Maintenance

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revealed on 10/04/12, SRNA #2 clocked in for work at 5:50 AM and clocked out at 9:59 PM.

Interview, on 10/15/12 at 10:20 AM, with the DON revealed the posting in the staff break room indicated there was twenty-four (24) hours in which to report abuse. However, she stated she had made it clear that any sign of abuse was to be reported immediately to the Nurse in charge or the Supervisor. The DON stated she did not know why the posting was in the break room. She stated she could see where staff misunderstood the posting; however, that was not what they were taught.

Additional interview, on 10/19/12 at 6:58 PM, with the DON revealed the nurses (LPNs and RNs) were the Supervisors for SRNAs. She indicated in her interviews with staff they didn't always feel comfortable reporting to the nurse, so she had posted her phone number, the Assistant Director of Nursing's (ADON) phone number, and the Administrator's phone number in the break room. The DON stated she was first made aware of the abusive incident allegations on 10/05/12 at approximately 9:30 AM to 10:00 AM. Per interview, she had identified a pattern with residents involved in the abusive incidents, and that most of residents could not voice concerns or issues. She stated she immediately had the nurses perform skin assessments on the residents and immediately suspended SRNA #2. She stated she did not know where the posting related to twenty-four (24) hour reporting had come from.

Interview, on 10/19/12 at 7:27 PM, with the Administrator revealed the posting which

F 223
Supervisor, Business Office Manager, and Dietary Manager. The Medical Director and Pharmacist also attend the CQI meeting quarterly, at a minimum. The members of the Focus Committee and CQI Committee will make recommendations regarding further monitoring and continued compliance.

F226
It is the policy of Wurland Nursing and Rehabilitation Center to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property as specified in 483.13.

SRNA #2 was immediately suspended from work by the Director of Nursing (registered nurse) on 10/5/12 until her eventual termination by the Director of Nursing (registered nurse) on 10/18/12. SRNA #3, #4, #6 were given disciplinary actions and education by the Director of Nursing (registered

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Indicated a time of twenty-four (24) hours to report abuse had come from "Corporate", and it's use was to walk staff through how to report abuse themselves. He stated the facility's expectation was for abuse to be reported "as soon as practicable, immediately as defined by the federal regulations" and staff should not wait twenty-four (24) hours.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 10/23/12 that alleged removal of the Immediate Jeopardy (IJ) on 10/21/12, based on the following:

1. All residents in the facility underwent skin assessments, starting 10/05/12, by Licensed Nurses.
2. All interviewable residents were interviewed regarding if they had experienced any form of mistreatment in the facility by the DON, ADON, Staff Development Nurse and Social Services Director. Responsible parties were notified of the abuse allegations starting on 10/05/12.
3. All facility staff received education on the facility Abuse Protocols on 10/19/12 and 10/20/12, by the DON, ADON and Staff Development Nurse. The education was all inclusive of the facility's abuse policies, with special emphasis on reporting immediately any suspected abuse. Immediately was clarified (as soon as you see it or suspect it and resident safety had been secured).
4. Additional education was provided to the Administrator, by the Continuous Quality director for Kentucky, related to the Resident Advocacy

F 223

nurse) regarding reporting requirements prior to returning to work. LPN #3 was educated regarding reporting requirements by the Director of Nursing (registered nurse) on 10/19/12. RN #1 was educated on 10/19/12 and issued a disciplinary action resulting in termination on 10/24/12 by the Director of Nursing (registered nurse).

Residents #2, #3, #4, #5, and #6 identified during staff interviews as having been allegedly mistreated were not interviewable. Pain assessments and skin assessments were completed on 10/5/12 by the MDS Coordinator (registered nurse), RN Supervisor (registered nurse) and Assistant Director of Nursing (registered nurse) for the 5 residents who were identified with no issues noted. The Medical Director was notified regarding each of these five residents on 10/5/12 with no new orders received. All responsible parties were notified, with the exception of one responsible party

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Protocols which included the correct abuse policy.

5. During staff interviews, conducted by the DON and ADON, it was identified that the Elder Abuse federally required posting in the employee break room stated that immediate reporting was required but identified the time frame as two (2) to twenty-four (24) hours. The posting was removed from the employee break room and placed in an alternate area, by the time clock on 10/19/12. This posting was identified as a possible root cause of timely reporting. All staff was educated on 10/19/12 and 10/20/12, by the DON, ADON and Staff Development Nurse, on the clear expectation of immediate reporting and immediate was clarified (as soon as you see it or suspect it and resident safety had been secured). New hires would be provided the education by the Staff development Nurse during orientation.

6. The Activities Director, Administrator and Social Services Director hold a Resident Council Meeting on 10/22/12 to determine if residents felt safe. The Administrator, Social Services Director, or Activity Director will conduct Resident Council Meetings on a weekly basis for four (4) weeks to determine that residents feel safe and that residents are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family members or visitors. Any concerns will be forwarded to the Administrator or DON.

7. Results of the Resident Council Meetings will be discussed weekly in the facility Focus Interdisciplinary Team (IDT) meetings. The IDT meets every Thursday and is a sub-committee of the facility's Continuous Quality Improvement

F 223

who has continued to be unavailable to our phone calls. A letter was sent on 10/20/12 asking this responsible party to call the facility as we were unable to contact them despite many attempts. The responsible parties who were contacted were interviewed by the Director of Nursing on 10/5/12. None of the families indicated any change in resident behavior but were encouraged to contact the Director of Nursing with any changes or information.

All residents in the facility underwent skin assessments on 10/5/12 by 3 MDS Coordinators (2 registered nurses and 1 licensed practical nurse), RN Supervisor (registered nurse) Assistant Director of Nursing (registered nurse), and Staff Development Coordinator (registered nurse) with no issues noted. All interviewable residents on the unit where the SRNA was permanently assigned (front hall) were interviewed by the Assistant Director of Nursing (a registered

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(CQI) Committee. Results of the IDT meetings will be forwarded to the CQI meeting the second Wednesday of every month.

8. The Administrator, DON, ADON, or Staff Development Coordinator will conduct a total of fifteen (15) staff interviews per week for eight (8) weeks regarding the abuse policy. The interviews are to be conducted on all shifts and in all departments.

9. Additional education was provided to the Administrator and DON regarding their duties and responsibilities for effective administering of the facility's Abuse Policies on 10/19/12 by the Continuous Quality Director for Kentucky.

10. Cell phone numbers of the Administrator, DON, and ADON were posted at each nurse's station on 10/06/12 and at the time clock on 10/07/12.

On 10/26/12, the State Agency verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AoC, effective 10/21/12, based on the following:

Interview, on 10/26/12 at 3:15 PM, with the DON revealed all facility residents had received a skin assessment after the abuse allegations were made. Record review of four (4) resident's records (Residents #9, #10, #11, and #12) revealed skin assessments had been performed.

Interview, on 10/26/12 at 3:15 PM, with the Director of Nursing (DON) revealed all interviewable residents in the facility had been interviewed on 10/20/12 related to how staff

F 223 nurse) and the Registered Nurse/MDS Coordinator on 10/05/12. All interviewable residents in the remaining unit (back hall) were interviewed by the Director of Nursing (a registered nurse) and the Assistant Director of Nursing (a registered nurse) on 10/20/12. All residents were asked if they had ever experienced any form of mistreatment in this facility. No resident reported any form of mistreatment. During the interviews, these residents were also encouraged to voice any concerns now and ongoing with no concerns noted at this time. A Brief Interview for Mental Status (BIMS-Section C on MDS) was completed for the non-interviewable residents on the unit where the SRNA was permanently assigned (front hall) by the MDS Coordinator (a registered nurse) on 10/19/12 and showed no declines from previous BIMS scores.

The Administrator and the Regional Continuous Quality

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treated them, if they felt safe, and if they felt comfortable reporting issues. Interview, on 10/25/12 at 2:40 PM with Resident #8, at 2:45 PM, with Unsampled Resident A at 2:55 PM, and with Resident #7 at 3:08 PM, revealed they had been interviewed by facility staff recently related to how they were treated, if they felt safe, and if they were comfortable reporting issues.

Interview, on 10/18/12 at 11:25 AM, with an unsampled resident, and on 10/19/12 at varying times with eight (8) unsampled residents revealed no complaints of abuse or mistreatment by facility staff. Interview, on 10/18/12 at 6:25 PM, with Resident #6's responsible party revealed she had been informed of the abuse allegations.

Interview, on 10/18/12 at 6:40 PM, with Resident #4's responsible party revealed she had been informed of the abuse allegations. Interview, on 10/18/12 at 6:58 PM, with Resident #3's responsible party revealed she had been informed of the abuse allegations.

Review of the Inservice records, dated 10/19/12 and 10/20/12 revealed all levels of facility staff, including Dietary, Housekeeping, and Laundry staff, received additional education on the facility's abuse policies with "Immediate" being clarified. Interview, on 10/25/12 at 4:33 PM with Housekeeper #1; at 4:33 PM with SRNA #1; at 4:50 PM with LPN #6; at 4:56 PM with LPN #2; at 6:14 PM with SRNA #12, who all worked the 2:00 PM to 10:00 PM shift, and at 6:22 PM with SRNA #10 (who worked the 10:00 PM to 6:00 AM shift), revealed they had all received additional education on abuse which included clarification of "Immediate".

F 223

Improvement Nurse (registered nurse) conducted a review of facility Abuse Policies on 10/19/12. The facility policies include the required components of F226. Listed below are the facility interpretation and implementation guidelines for F226.

- Screening – interpretation
 - The facility has in place a system to prevent employment of individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law
 - The facility has in place a system to prevent employment of individuals who have had a finding entered into the State nurse aide

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ID PREFIX TAG

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Interview, on 10/26/12 at 9:10 AM with Housekeeper #3; at 9:20 AM with LPN #5; at 9:20 AM with Housekeeper 2; at 9:27 AM with Dietary Aide #1; at 9:30 AM with Housekeeper #4; at 9:34 AM with Dietary Aide #2; at 9:40 AM with LPN #7; at 9:45 AM with Housekeeper #5; at 9:52 AM with SRNA #13; at 10:00 AM with Laundry Personnel #1; at 10:06 AM with Cook #1; at 10:10 AM with SRNA #14; at 10:25 AM with SRNA #15; at 10:50 AM with SRNA #16; at 11:03 AM with Valet #1; at 11:08 AM with SRNA #17 (who usually worked the 2:00 PM to 10:00 PM shift); at 11:10 AM with SRNA #23; at 11:20 AM with SRNA #18; at 11:26 AM with SRNA #19 and #24; at 11:33 AM with SRNA #20; at 11:35 AM with SRNA #22; at 11:45 AM with SRNA #21; at 12:55 PM with RN #1 (who worked the 10:00 PM to 6:00 AM shift); and at 2:20 PM with SRNA #25 (who worked the 10:00 PM to 6:00 AM shift), revealed they had all received additional education on abuse which included clarification of "Immediate".

Observation, on 10/26/12 at 2:15 PM, of the area surrounding the time clock revealed the federally required posting related to Elder Abuse was present. Additionally, the Administrator's, DON's, and ADON's phone numbers were also present in this area.

Interview, on 10/26/12 at 3:55 PM, with the Administrator revealed he had received education related to the correct abuse policy, and on administering the facility as per the AoC. The Administrator stated a Resident Council Meeting had been held that week, and would be held every week for four (4) weeks as per the AoC. He stated results of the Resident Council Meetings would be discussed weekly in the facility Focus

F 223

concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

- o The facility's system is to assure that the facility does whatever is within its control to prevent resident abuse.
- Implementation
- o The facility will obtain a request for criminal background history on each employee at the time of hire.
- o The facility will check the State Nurse Aide Registry for confirmation that the potential employee is not listed on the registry and the facility will

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Interdisciplinary Team (IDT) meetings. Results of the IDT meetings would be forwarded to the CQI meeting the second Wednesday of every month. In addition, he stated staff interviews were being conducted to ensure staff were knowledgeable of the Abuse policy. The Administrator stated a total of fifteen (15) staff interviews per week for eight (8) weeks regarding the abuse policy would be conducted.

Review of the Staff Abuse Questionnaire forms dated, 10/24/12, revealed the Administrator had conducted seven (7) staff interviews. Review of the Staff Abuse Questionnaire forms, dated 10/25/12, revealed the Administrator had conducted two (2) staff interviews.

Interview, on 10/26/12 at 3:15 PM, with the Director of Nursing (DON) revealed she had been re-educated on the facility abuse policy and the administering of the facility by the Continuous Quality Improvement Director for Kentucky. She stated the Abuse policy given to the surveyors previously had been the incorrect one. She stated education was provided for all facility staff; and some staff interviews related to the education had been performed already that week. According to the DON, the staff interviews were to take place for eight (8) weeks, and if staff did not answer correctly they would receive a one on one education to ensure they were knowledgeable. In addition, she stated a Resident Council Meeting had been held earlier in the week, and if there were nursing issues she or the Assistant Director of Nursing (ADON) would be notified so they could decide what needed to be done.

F 223

confirm proper licensing with licensing authorities.

- o The facility will check references of potential employees
- Training – interpretation
 - o The facility has in place a system to train both new employees and ongoing training for all employees in relation to the abuse, neglect, and exploitation and misappropriation policy.
 - o The facility trains employees upon hire regarding the abuse, neglect, and exploitation and misappropriation policy.
 - o The facility trains employees semi-

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Interview, on 10/26/12 at 4:20 PM, with the Continuous Quality Improvement Director for Kentucky revealed she had re-educated the Administrator and DON on the correct facility Abuse policy.

The facility remained out of compliance at a lower Scope and Severity of a "L", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).

F 223

annually regarding the abuse, neglect, and exploitation and misappropriation policy.

F 226 483.13(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.

F 226

- o The facility also utilizes the electronic educational system called Silverchair Learning Systems as a means of further educating the staff on the abuse, neglect, exploitation and misappropriation policy.
- o The facility also trains staff on an as needed basis regarding the abuse, neglect, exploitation and misappropriation policy.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure policy and procedures were implemented to protect residents from abuse for five (5) of twelve (12) sampled residents (Residents #2, #3, #4, #5, and #6). Three (3) different State Registered Nursing Assistants (SRNAs) witnessed SRNA #2 be physically and verbally abusive to five (5) residents on 10/04/12 starting at approximately 7:30 AM and continuing until after the evening meal. Two licensed staff, Licensed Practical Nurse (LPN) #3 and Registered Nurse (RN) #1 were also aware of the

Prevention - interpretation

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alleged abuse. However, the staff failed to notify a Supervisor of the witnessed abuse immediately as per facility policy. This failure allowed SRNA #2 to continue providing care to other residents until her shift ended at 9:59 PM on 10/04/12. The alleged abuse was not reported to Administrative staff until approximately 9:30 AM on 10/05/12. (Refer to F-223)

The facility's failure to implement policy and procedures to protect residents from abuse placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 10/19/12 and was determined to exist on 10/04/12. The facility was notified of the Immediate Jeopardy on 10/19/12. Substandard Quality of Care (SQC) was identified at 42 CFR 483.13, Resident Behavior and Facility Practice.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 10/23/12 with the facility alleging removal of the Immediate Jeopardy on 10/21/12. The State Survey Agency verified removal of Immediate Jeopardy as alleged in the acceptable AoC on 10/21/12 prior to exiting the facility on 10/26/12. However, non-compliance continued to exist at 42 CFR 483.13 Resident Behavior and Facility Practice, with a scope and severity of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure policy and procedures were implemented to protect residents from abuse.

The findings include:

Review of the facility's policy titled, "Abuse,

F 226

- o The facility will have appropriate orientation and training programs within its control; educate staff to prevent resident abuse.
- Implementation
- o The facilities orientation program for all new employees shall provide instruction of "Residents Rights" and the facility's policies regarding abuse.
- o The facilities orientation and training program shall include how to appropriately intervene in situations where the resident has become aggressive or is exhibiting catastrophic

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Neglect, and Exploitation", dated 07/01/09 revealed when abuse, mistreatment, exploitation, or neglect is suspected, the person who suspects abuse will immediately notify the Supervisor. The Supervisor was to notify the Administrator or Director of Nursing (DON), who would complete an incident report immediately and initiate an investigation.

Interview, on 10/17/12 at 11:20 AM, with SRNA #4 and review of her written statement revealed on 10/04/12 at approximately 7:30 AM, she observed SRNA #2 jerking Resident #5's brief up and heard SRNA #2 raise her voice and tell Resident #5 to "fucking help you dumbass". SRNA #2 continue to jerk on Resident #5 and the resident told SRNA #2 she was being rough. When SRNA #2 assisted Resident #5 into his/her wheelchair, SRNA #2 screamed, "fucking help, (Resident #5) goddamn". SRNA #4 placed Resident #5's hat on his/her head and SRNA #2 jerked it off his/her head and "slung it across the room". SRNA #2 stated to the resident, "...this is fucking ridiculous" and left the room. Per interview, SRNA #4 did not immediately report the abuse. She reported she witnessed abuse to LPN #3 and RN #1 when she returned to work on 10/04/12 at 10:00 PM. However, SRNA #4 failed to immediately report the alleged abuse immediately to a Supervisor as per the facility policy.

Interview, on 10/17/12, with RN #1 revealed he worked the 10:00 PM to 6:00 AM shift. The RN stated SRNA #4 did report the abusive incidents, she had witnessed earlier in the day on 10/04/12, to him. However, SRNA #4 was not making an official report to him, so he referred her to the DON. The RN stated even though SRNA #4

F 226

- behavior.
- o The facility will provide additional educational training as determined by the administrator or the CQI committee or as outlined in other policies relating to orientation and training.
- Identification - interpretation
 - o The facility will use the resident MDS process, medical records and family history, if available, to determine any predisposing factors to abuse or neglect.
- Implementation
 - o The assessment should strive to

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reported the abuse to him, he felt it would be better for her (SRNA #4) to report it as she was the person who had observed it. RN #1 stated he thought the time frame for reporting abuse was twenty-four (24) hours. According to the RN, he had had no extensive teaching on the facility's abuse policy since being hired in November, 2011. There was no documented evidence RN #1 notified the Administrator or DON as per facility policy so an incident report could be completed and an investigation initiated.

Interview, on 10/16/12 at 7:20 PM, with SRNA #6 revealed somewhere between 10:00 AM and 12:00 PM on 10/04/12, during Resident #2's bath, the resident started "fighting". SRNA #6 stated SRNA #2 said "god damn it" to the resident and then open handedly slapped Resident #2 on his/her left shoulder. According to SRNA #6, the area where SRNA #2 slapped Resident #2 "immediately" started turning red. SRNA #6 stated he didn't know what to do as he had never witnessed anything like that. The SRNA stated he "thought if she did this in front of me then what would she do in a room by herself". Per interview, SRNA #6 indicated he did not remember "the exact timing on reporting". He stated he did tell SRNA #10 that night about the abuse he witnessed. However, there was no documented evidence SRNA #6 immediately notified a Supervisor as per facility policy after witnessing the abuse by SRNA #2.

Interview, on 10/12/12 at 4:30 PM, with SRNA #3 revealed on 10/04/12 SRNA #2 was being "rough" with Resident #3. She stated Resident #3 exhibited "behavior problems" at times and was also resistant to care. SRNA #3 stated Resident

F 226

determine the identification of residents whose personal histories render them at risk for abusing other residents or for aggressive behavior with staff

- o Development of appropriate intervention strategies to prevent occurrences utilizing the Interdisciplinary Care Plan.
- o Monitoring of the resident for any changes that would trigger abusive behavior and assessment of the strategies on a regular basis.
- o The assessments should strive to determine the identification of

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#3 "smacked" SRNA #2 on the hands and SRNA #2 "smacked" the resident back on the hand. In an interview, on 10/12/12 at 4:45 PM, with SRNA #3 she stated on 10/04/12 she was assisting Resident #4's roommate and SRNA #2 was assisting Resident #4 she heard Resident #4 tell SRNA #2 she was hurting him/her, and pulling on him/her too hard. SRNA #3 stated she asked SRNA #2 if she needed help and SRNA #2 stated "no" she could do the resident herself. SRNA #3 stated she heard SRNA #2 tell Resident #4, "come on (Resident #4), it's the same shit just a different day". Continued interview with SRNA #3 revealed on 10/04/12, SRNA #2 told Resident #6 she was "going to knock" him/her "the fuck out" and called the resident an old "son of a bitch". She stated SRNA #2 had been "rough" with Resident #6 before and cursed at the resident.

Additional interview, on 10/18/12 at 9:00 PM, with SRNA #3 revealed she thought she had twenty-four (24) hours to report the abuse because of a poster she had seen in the breakroom. She stated she did not report the abuse to the DON as she wasn't in the facility at the time, and she didn't have a telephone number at which to phone her, (DON). There was no documented evidence SRNA #3 immediately notified a Supervisor of the abusive incidents she witnessed SRNA #2 do on 10/04/12 after the evening meal.

Interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed on the morning of 10/04/12 SRNA #4 was "upset" and told SRNA #10 she had witnessed SRNA #2 "jerk[ing]" Resident #5 up, and cursing and screaming at him/her. According to SRNA #10, she told SRNA #4 she needed to

F 226

residents who are at risk for being abused/neglected and the development of appropriate intervention strategies to prevent occurrences utilizing the Interdisciplinary Case Plan.

- Investigation -- interpretation
 - The facility will promptly (as soon as the incident or suspicion is reported) investigate all reported or suspected allegations of abuse.
- Implementation -- The person(s) observing an incident of resident abuse or suspecting resident abuse must

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/26/2012
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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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report the abuse, however she stated she had always been told they had twenty-four (24) hours to report it if it wasn't something that was "going to be harm". She stated she "honestly" thought SRNA #4 had twenty-four (24) hours to report the abuse.

Continued interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed on 10/04/12 at approximately 10:20 PM, SRNA #3 told her SRNA #2 cursed and screamed at Resident #4; jerked Resident #6's clothes off; and, yelled at Resident #3 and took the resident's hand and "open handed slapped it several times". She stated SRNA #3 felt she needed to report the abuse to the DON or ADON, but there was no way to do so as she didn't have their telephono numbers.

Further interview, on 10/18/12 at 7:47 AM, with SRNA #10 revealed at approximately 11:30 PM on 10/04/12, SRNA #6 telephoned her and reported he had witnessed SRNA #2 being verbally and physically abusive to Resident #2 earlier that day. She stated SRNA #6 felt that he needed to report the abuse, however didn't know what to do. SRNA #10 stated she told SRNA #6 he had to report the abuse and she would go with him to report it the next morning. SRNA #10 stated at approximately 9:30 AM on 10/05/12, the Assistant Director of Nursing (ADON) was notified of the abusive incidents by SRNA #2 that were witnessed by SRNA's #3, #4, and #6. She stated the ADON asked all involved to write out their statements, which they did. SRNA #10 stated the DON told them they should have reported the abuse sooner, however SRNA #10 stated they were still within the twenty-four (24) hour time frame at that time.

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immediately (as soon as you see it or suspect it and resident safety has been secured) report such incidents to their supervisor. The following information should be reported to their supervisor.

1. The name of the resident involved.
2. The date and time the incident occurred
3. Where the incident took place
4. The name(s) of the person (s) committing the incident, if known
5. The name of any witnesses to the incident
6. The type of abuse that was committed (i.e. verbal, physical, sexual, etc.)
7. Any additional

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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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Review of the facility's final "Resident Abuse & Neglect Investigation Report Form", completed by the Director of Nursing (DON) revealed the incident date as 10/04/12, and the date the incident was reported as 10/05/12. Review revealed SRNA #10 reported the incidents and there were three (3) witnesses listed in the incidents (State Registered Nursing Assistants #3, #4, and #6). Under the summary of the witness interviews it was documented all three (3) witnesses reported witnessing Stated Registered Nursing Assistant (SRNA) #2 curse at residents, and SRNA #3 and #6 reported witnessing SRNA #2 "upon handedly smacking" two residents. Under the summary of investigator's findings section of the Form the DON documented "Residents unable to confirm or deny events. Assessments revealed no marks, bruises, pain or evidence that physical abuse occurred. All events witnessed by one other staff member only." The DON documented under the "did the findings indicate that abuse occurred", "no". She documented "unable to substantiate due to lack of evidence". Further review of the Form revealed the DON signed and dated the Form on 10/08/12.

Interview, on 10/10/12 at 6:58 PM, with the DON revealed LPNs and sometimes RNs were the direct Supervisor for SRNAs. The DON stated she did not know where the posting related to twenty-four (24) hour reporting had come from. The DON stated she was first made aware of the abusive incident allegations on 10/05/12 at approximately 9:30 AM to 10:00 AM. She stated she immediately had the nurses perform skin assessments on the residents and immediately

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information that may be requested by the supervisor or known by the person reporting the abuse.

- Protection -- interpretation
 - o The facility has a system to protect all residents from abuse during the investigation.
- Implementation
 - o Employees of the facility that have been accused of resident abuse will be suspended from work immediately (as soon as you see it or suspect it and resident safety has been secured) pending an internal investigation.
 - o While the investigation is being conducted, accused individuals not

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suspended SRNA #2. Per interview, she had unsubstantiated the abuse allegations on her final investigation report, because there was no evidence of abuse, no mark on the residents SRNA#2 had allegedly struck, and no resident could say they were verbally abused. However, she had identified a pattern with the residents involved, stating "most of them can't voice concerns or issues".

Further interview, on 10/26/12 at 3:15 PM, with the DON revealed she was unaware SRNA #4 had reported the abuse she had witnessed in RN #1 on the 10:00 PM to 6:00 AM on 10/04/12, until 10/24/12 when the State Survey Agency reported their findings to the facility.

Interview, on 10/19/12 at 7:27 PM, with the Administrator revealed the posting which indicated a time of twenty-four (24) hours to report abuse had come from "Corporate", and it's use was to walk staff through how to report abuse themselves. Per interview, the Administrator stated staff should report as soon as practicable, "the sooner the better". He stated the DON or ADON usually took the lead in investigations and he had only briefly reviewed the final investigation report of the alleged abuse due to being out of town. He further stated three (3) eyewitnesses to abuse would be enough evidence to substantiate the allegation.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 10/23/12 that alleged removal of the Immediate Jeopardy (IJ) on 10/21/12, based on the following:

1. All residents in the facility underwent skin

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employed by the facility will be denied unsupervised access to the resident. Visits will be supervised by a facility staff member selected by the Administrator or Director of Nursing (a registered nurse) and may only be made in public areas, such as the front lobby, where high volumes of people are present.

- Reporting – interpretation
 - o Any alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation

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assessments, starting 10/05/12, by Licensed Nurses.

2. All interviewable residents were interviewed regarding if they had experienced any form of mistreatment in the facility by the DON, ADON, Staff Development Nurse and Social Services Director. Responsible parties were notified of the abuse allegations starting on 10/05/12.

3. All facility staff received education on the facility Abuse Protocols on 10/19/12 and 10/20/12, by the DON, ADON and Staff Development Nurse. The education was all inclusive of the facility's abuse policies, with special emphasis on reporting immediately any suspected abuse. Immediately was clarified (as soon as you see it or suspect it and resident safety had been secured).

4. Additional education was provided to the Administrator, by the Continuous Quality director for Kentucky, related to the Resident Advocacy Protocols which included the correct abuse policy.

5. During staff interviews, conducted by the DON and ADON, it was identified that the Elder Abuse federally required posting in the employee break room stated that immediate reporting was required but identified the time frame as two (2) to twenty-four (24) hours. The posting was removed from the employee break room and placed in an alternate area, by the time clock on 10/19/12. This posting was identified as a possible root cause of timely reporting. All staff was educated on 10/19/12 and 10/20/12, by the DON, ADON and Staff Development Nurse, on the clear expectation of immediate reporting and

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of resident property must be reported to the Administrator by the supervisor immediately (as soon as it is reported or suspected and resident safety has been secured) via phone call or in person. If the Administrator is unavailable, the DON or ADON will be notified in person or via phone. Cell phone numbers of these individuals are posted at each nurses station and at the time clock. If an allegation of abuse is directed at the Administrator, the employee is to call the Employee Compliance Line at 1-888-508-9774

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immediate was clarified (as soon as you see it or suspect it and resident safety had been secured). New hires would be provided the education by the Staff development Nurse during orientation.

6. The Activities Director, Administrator and Social Services Director held a Resident Council Meeting on 10/22/12 to determine if residents felt safe. The Administrator, Social Services Director, or Activity Director will conduct Resident Council Meetings on a weekly basis for four (4) weeks to determine that residents feel safe and that residents are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family members or visitors. Any concerns will be forwarded to the Administrator or DON.

7. Results of the Resident Council Meetings will be discussed weekly in the facility Focus Interdisciplinary Team (IDT) meetings. The IDT meets every Thursday and is a sub-committee of the facility's Continuous Quality Improvement (CQI) Committee. Results of the IDT meetings will be forwarded to the CQI meeting the second Wednesday of every month.

8. The Administrator, DON, ADON, or Staff Development Coordinator will conduct a total of fifteen (15) staff interviews per week for eight (8) weeks regarding the abuse policy. The interviews are to be conducted on all shifts and in all departments.

9. Additional education was provided to the Administrator and DON regarding their duties and responsibilities for effective administering of the facility's Abuse Policies on 10/19/12 by the

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All reports will be thoroughly investigated.

Implementation

- o The supervisor will promptly (as soon as it is reported or suspected and resident safety has been secured) notify the Administrator or DON (a registered nurse) and start the investigation.
- o The facility Administrator or DON (a registered nurse) shall notify their State Adult Protective Services Agency and their state licensing agency of the suspected occurrence and others as required by regulation.
- o Report the results of the investigation to the above listed

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Continuous Quality Director for Kentucky.

10. Cell phone numbers of the Administrator, DON, and ADON were posted at each nurse's station on 10/06/12 and at the time clock on 10/07/12.

On 10/26/12, the State Agency verified the immorality of the IJ was removed and the facility implemented corrective actions as alleged in the AoC, effective 10/21/12, based on the following:

Interview, on 10/26/12 at 3:15 PM, with the DON revealed all facility residents had received a skin assessment after the abuse allegations were made. Record review of four (4) resident's records (Residents #3, #10, #11, and #12) revealed skin assessments had been performed.

Interview, on 10/26/12 at 3:15 PM, with the Director of Nursing (DON) revealed all interviewable residents in the facility had been interviewed on 10/20/12 related to how staff treated them, if they felt safe, and if they felt comfortable reporting issues. Interview, on 10/25/12 at 2:40 PM with Resident #6, at 2:45 PM, with Unsampled Resident A at 2:55 PM, and with Resident #7 at 3:08 PM, revealed they had been interviewed by facility staff recently related to how they were treated, if they felt safe, and if they were comfortable reporting issues.

Interview, on 10/18/12 at 11:25 AM, with an unsampled resident, and on 10/19/12 at varying times with eight (8) unsampled residents revealed no complaints of abuse or mistreatment by facility staff. Interview, on 10/18/12 at 6:25 PM, with Resident #6's responsible party revealed she had

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agencies as well as, the resident, the resident's sponsor or legal representative and to other officials within five working days.

- Response – interpretation and implementation
 - The facility will review the facts determined by the investigation and determine what corrective action should be made, if any, to prevent a similar occurrence.
 - If system changes are needed, it will be the responsibility of the Administrator to direct development and implementation of these system changes.

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been informed of the abuse allegations. Interview, on 10/18/12 at 6:40 PM, with Resident #4's responsible party revealed she had been informed of the abuse allegations. Interview, on 10/18/12 at 6:58 PM, with Resident #3's responsible party revealed she had been informed of the abuse allegations.

Review of the Inservice records, dated 10/19/12 and 10/20/12 revealed all levels of facility staff, including Dietary, Housekeeping, and Laundry staff, received additional education on the facility's abuse policies with "immediate" being clarified. Interview, on 10/25/12 at 4:33 PM with Housekeeper #1; at 4:33 PM with SRNA #1; at 4:50 PM with LPN #8; at 4:56 PM with LPN #2; at 6:14 PM with SRNA #12, who all worked the 2:00 PM to 10:00 PM shift; and at 6:22 PM with SRNA #10 (who worked the 10:00 AM to 6:00 AM shift), revealed they had all received additional education on abuse which included clarification of "immediate".

Interview, on 10/26/12 at 9:10 AM with Housekeeper #3; at 9:20 AM with LPN #5; at 9:20 AM with Housekeeper 2; at 9:27 AM with Dietary Aide #1; at 9:30 AM with Housekeeper #4; at 9:34 AM with Dietary Aide #2; at 9:40 AM with LPN #7; at 9:45 AM with Housekeeper #5; at 9:52 AM with SRNA #13; at 10:00 AM with Laundry Personnel #1; at 10:05 AM with Cook #1; at 10:10 AM with SRNA #14; at 10:25 AM with SRNA #15; at 10:50 AM with SRNA #16; at 11:03 AM with Vatel #1; at 11:08 AM with SRNA #17 (who usually worked the 2:00 PM to 10:00 PM shift); at 11:10 AM with SRNA #23; at 11:20 AM with SRNA #18; at 11:25 AM with SRNA #19 and #24; at 11:33 AM with SRNA #20; at 11:35 AM with SRNA #22; at 11:45

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- The CQI Committee in the facility shall be responsible for monitoring the effectiveness of these new system changes.

All facility staff (this includes all disciplines, departments, and shifts) received additional education regarding Abuse, neglect, exploitation, resident rights and allegation reporting from 10/5/12-10/11/12 by Staff Development Coordinator (registered nurse). This education was derived from the correct policies.

The Administrator, Director of Nursing (a registered nurse) and Regional Continuous Quality Improvement Director (registered nurse) reviewed the Facility Abuse Policy provided to the surveyor on 10/19/12. It was noted that the policy provided to the surveyor was not the current policy regarding Abuse, Neglect

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AM with SRNA #21; at 12:55 PM with RN #1 (who worked the 10:00 PM to 6:00 AM shift); and at 2:20 PM with SRNA #25 (who worked the 10:00 PM to 6:00 AM shift), revealed they had all received additional education on abuse which included clarification of "immediate".

Observation, on 10/26/12 at 2:15 PM, of the area surrounding the time clock revealed the federally required posting related to Elder Abuse was present. Additionally, the Administrator's, DON's, and ADON's phone numbers were also present in this area.

Interview, on 10/26/12 at 3:55 PM, with the Administrator revealed he had received education related to the correct abuse policy, and on administering the facility as per the AoC. The Administrator stated a Resident Council Meeting had been held that week, and would be held every week for four (4) weeks as per the AoC. He stated results of the Resident Council Meetings would be discussed weekly in the facility Forum Interdisciplinary Team (IDT) meetings. Results of the IDT meetings would be forwarded to the CQI meeting the second Wednesday of every month. In addition, he stated staff interviews were being conducted to ensure staff were knowledgeable of the Abuse policy. The Administrator stated a total of fifteen (15) staff interviews per week for eight (8) weeks regarding the abuse policy would be conducted.

Review of the Staff Abuse Questionnaire forms dated, 10/24/12, revealed the Administrator had conducted seven (7) staff interviews. Review of the Staff Abuse Questionnaire forms, dated 10/25/12, revealed the Administrator had

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and Exploitation. The current policy states in part, "When abuse, mistreatment, exploitation or neglect is suspected, the person who suspects the abuse will immediately (as soon as you see it or suspect it and resident safety has been secured) notify the supervisor." These policies have been developed and implemented in order to prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. On 10/19/12, the Regional Continuous Quality Improvement Director (registered nurse) provided additional education to the Administrator related to the current Resident Advocacy Protocols. Special emphasis included the current Abuse Neglect and Exploitation Policy (RAP-IV-003), issued July 1, 2009 by the VP, Quality Management and Clinical Services and VP, Corporate Compliance & Risk Management, which states, in part, that "when abuse, mistreatment, exploitation or neglect is suspected, the person who suspects the abuse will

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conducted two (2) staff interviews.

Interview, on 10/26/12 at 3:15 PM, with the Director of Nursing (DON) revealed she had been re-educated on the facility abuse policy and the administering of the facility by the Continuous Quality Improvement Director for Kentucky. She stated the Abuse policy given to the surveyors previously had been the incorrect one. She stated education was provided for all facility staff, and some staff interviews related to the education had been performed already that week. According to the DON, the staff interviews were to take place for eight (8) weeks, and if staff did not answer correctly they would receive a one on one education to ensure they were knowledgeable. In addition, she stated a Resident Council Meeting had been held earlier in the week, and if there were nursing issues she or the Assistant Director of Nursing (ADON) would be notified so they could decide what needed to be done.

Interview, on 10/26/12 at 4:20 PM, with the Continuous Quality Improvement Director for Kentucky revealed she had re-educated the Administrator and DON on the correct facility Abuse policy.

The facility remained out of compliance at a lower Scope and Severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).

F 226 immediately (as soon as you see it or suspect it and resident safety has been secured) notify the Supervisor." Additional education included information related to the current Resident Abuse policy (RAP-IV-001) which states, in part, "the Supervisor shall ensure resident safety and immediately (as soon as it is reported or suspected and resident safety has been secured) notify the Administrator or Director of Nursing."

All facility staff (this includes all disciplines, departments, and shifts) received education regarding Facility Abuse Protocols by Director of Nursing (a registered nurse) the Assistant Director of Nursing (a registered nurse), and the Staff Development Coordinator (a registered nurse) on 10/19/12 and 10/20/12. This education was all inclusive of the Facility Abuse Policies but special emphasis was placed on Definitions of Abuse, the protection aspect of the policy and the reporting aspect of the

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged

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F 280	Continued From page 36 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 observation, interview, and record review it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of twelve (12) sampled residents, (Residents #12). Resident #12's care plan was not revised to reflect he/she did not require oxygen use. The findings include: Review of the facility's policy titled, "Comprehensive Plan of Care", dated 12/01/10, revealed it was the responsibility of all	F 280	policy including the fact of reporting any suspected abuse to your supervisor immediately (as soon as you see it or suspect it and resident safety has been secured). The education further explained that staff are never to use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion and that any violation of this policy would result in corrective action including termination. The definition of immediate was clarified as (as soon as you see it or suspect it and resident safety has been secured). The facility has engaged the services of an independent contractor to provide Compassionate and Person Centered Training to the facility's direct care staff and facility administration. The facility does not employ any agency staff. The independent contractor we have retained is:	
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NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 280 Continued From page 37

interdisciplinary team members involved in a resident's care to provide input into the Care Plan. Continued review revealed the interdisciplinary team included the nurse responsible for the resident's nursing care.

Observation, of Resident #12 on 10/26/12 at 11:15 AM, revealed the resident did not have oxygen in use and there was no evidence of oxygen equipment in the room.

Review of the medical record revealed the facility admitted Resident #12 on 08/18/12 with diagnoses which included Asthma, Chronic Obstructive Pulmonary Disease (COPD), and a history of smoking tobacco. Review of the Physician's Orders revealed no documented evidence of an order for oxygen therapy with humidification.

Review of the Admission Minimum Data Set (MDS) Assessment, dated 08/27/12, revealed the facility assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated no cognitive impairment. Further review revealed the facility assessed Resident #12 to have received oxygen therapy while being a resident.

Review of the Comprehensive Care Plan, dated 09/03/12, revealed a care plan that stated Resident #12 required oxygen therapy, and approaches included to administer oxygen as ordered, ensure that the oxygen supply was available at all times, change the tubing per protocol, and provide humidification as ordered.

Interview, on 10/26/12 at 4:20 PM, with State

F 280

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The contractor will forward a written report to CMS and the State providing the content of the training, documentation of objectives and attendees participating. During the course of the training the independent contractor and governing body (the Director of Nursing, Administrator, Medical Director, Regional Area Administrator, Regional Continuous Quality Improvement Nurse, and Regional Vice President) shall develop a mission statement that reflects a commitment to maintaining and improving quality for Medicare

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F 280 Continued From page 38

Registered Nursing Assistant (SRNA) #13 and SRNA #26 (who both worked the 2:00 PM to 10:00 PM shift) revealed they had never observed Resident #12 using oxygen.

Interview, on 10/26/12 at 4:30 PM, with Licensed Practical Nurse (LPN) #4 revealed Resident #12 had no order for oxygen therapy, and did not recall the resident ever being on oxygen.

Interview, on 10/25/12 at 3:10 PM, with the MDS Coordinator revealed care plans were updated daily based on Physician's Orders. She stated the nurse would occasionally update the care plan, but usually the MDS Coordinator would perform the update.

Interview, on 10/25/12 at 3:20 PM, with LPN #8, who was responsible for Resident #12's care plan, revealed she believed the resident was on oxygen therapy when he/she was first admitted to the facility. She stated there should have been an order for oxygen therapy. The LPN stated she would check and return with the information. Additional interview at 3:55 PM with LPN #8 revealed she was unable to locate a Physician's Order for oxygen therapy in Resident #12's medical record. She stated the Comprehensive Care Plan should have been revised because the resident did not have a Physician's Order and was not using oxygen.

Interview, on 10/26/12 at 5:00 PM, with the Director of Nursing (DON) revealed she had never observed Resident #12 to use oxygen. She stated the Comprehensive Care Plan should have been revised related to the resident not having oxygen in use.

F 280

completed on or before December 1, 2012.

The independent contractor will evaluate the skills and competency of direct care staff and facility administration on their ability to provide compassionate, person centered care. The contractor shall submit a written report to CMS and the State summarizing the outcomes of the competency skills evaluation of all staff required to take this training. Of particular importance is staff knowledge related to abuse and neglect. This evaluation process will be completed on or before December 1, 2012.

The independent contractor will conduct training for the governing body (the Director of Nursing, Administrator, Medical Director, Regional Area Administrator, Regional Continuous Quality Improvement Nurse, and Regional Vice President) and all facility personnel on how to create and maintain a proactive

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F 490 SS-1	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.</p> <p>The facility's Administration failed to have an effective system to ensure policy and procedures were implemented to protect residents from abuse; failed to ensure staff was knowledgeable of the facility's policy and procedures related to abuse; and, failed to ensure information made available to staff regarding abuse was accurate. On 10/04/12 three staff witnessed State Registered Nursing Assistant (SRNA) #2 verbally and/or physically abuse five residents (Residents #2, #3, #4, #5, and #6). Staff failed to report the abuse immediately and the alleged perpetrator continued to provide resident care for approximately fourteen and a half hours after the first alleged abusive incident was witnessed. (Refer to F-223 and F-226)</p> <p>The facility's failure to be administered in a manner which enabled it to use its resources</p>	F 490	<p>approach for identifying events and occurrences that may constitute or contribute to abuse and neglect. This training will be completed on or before December 1, 2012.</p> <p>The training provided by the independent contractor shall include a discussion of all types of abuse including but not limited to domestic abuse, institutional abuse and neglect, physical abuse, sexual assault, misuse of restraints, chemical restraints, physical restraints, emotional, psychological/verbal abuse, physical neglect, medical neglect, abandonment, and financial or material exploitation.</p> <p>The facility will provide written information on how to report elder abuse for all employees and facility administration on or before December 1, 2012. The facility does not employ any agency staff. The independent contractor shall also provide information to residents during a resident council meeting on abuse</p>		

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F 490 Continued From page 40
effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 10/19/12 and was determined to exist on 10/04/12. The facility was notified of the Immediate Jeopardy on 10/19/12. Substandard Quality of Care (SOC) was identified at 42 CFR 483.13, Resident Behavior and Facility Practice.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 10/23/12 with the facility alleging removal of the Immediate Jeopardy on 10/21/12. The State Survey Agency verified the removal of Immediate Jeopardy as alleged in the acceptable AoC on 10/21/12 prior to exiting the facility on 10/26/12. However, non-compliance continued to exist at 42 CFR 483.13 Resident Behavior and Facility Practice, with a scope and severity of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure residents remain free from abuse.

The findings include:

Review of the facility's policy "Abuse, Neglect, and Exploitation", dated 07/01/09 revealed when abuse, mistreatment, exploitation, or neglect is suspected, the person who suspects abuse will immediately notify the Supervisor.

On 10/04/12, from approximately 7:30 AM to after the evening meal, three (3) eyewitnesses, SRNAs #3, #4, and #6 observed SRNA #2

F 490 on or before December 1, 2012. A family council meeting will also be conducted by the independent contractor on a weekday (Thursday, November 29, 2012 at 7:00 p.m.) and a weekend (Saturday, December 1, 2012 at 10:00 a.m.) to discuss abuse and reporting with family members. All information regarding how to report abuse will be readily available on request. Training shall include a review of the requirements for reporting reasonable suspicion of a crime in a Long Term Care Facility (LTC) in accordance with S&C: 11-30-NH.

CMS and the State survey agency will be provided a signed and notarized attestation statement from the facility administrator verifying training has been provided to all staff on or before December 1, 2012. The facility does not employ any agency staff.

During staff interview it was identified that the Elder Abuse federally required posting in the

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F 490	Continued From page 41 cursing at five (5) residents (Residents #2, #3, #4, #5, and #6) and being physically abusive to two (2) of these residents (Residents #2 and #3). SRNA #2 was observed by SRNA #4 to jerk on Resident #5 and to curse at the resident. SRNA #2 was observed by SRNA #6 to open handedly slap Resident #2 on the shoulder leaving a red mark and to curse at the resident. SRNA #2 was observed by SRNA #3 to smack Resident #3's hand "a few times" and to curse at Residents #3, #4, and #6. However, SRNA #3, #4, and #6 failed to immediately notify a Supervisor of the abusive incidents as per the facility policy. Interviews with staff revealed they were under the impression they had 24 hours to report an abuse allegation. This allowed SRNA #2 to continue providing care to other residents until her shift ended at 9:50 PM on 10/04/12. Review of the facility's final "Resident Abuse & Neglect Investigation Report Form", completed by the Director of Nursing (DON) revealed "Residents unable to confirm or deny events. Assessments revealed no marks, bruises, pain or evidence that physical abuse occurred. All events witnessed by one other staff member only." Per the investigation, the DON was unable to substantiate the abuse occurred due to lack of evidence. Interview, on 10/19/12 at 6:58 PM, with the DON revealed she had unsubstantiated the abuse allegations on her final investigation report, because there was no evidence the abuse had occurred. Per the DON, there was no mark on the residents SRNA#2 had struck, and no resident could say they were verbally abused. However, the DON stated the residents who were	F 490	employee break room states that immediate reporting is required but identifies immediate as 2-24 hours. This posting was removed from the breakroom and was posted in an alternate area. This alternate area is by the time clock. The facility continues to meet federally mandated posting requirements as outlined in the Elder Abuse Act. This was identified as a possible root cause of timely reporting and a clear expectation of immediate reporting was included in the staff education provided to all staff (this includes all disciplines, departments, and shifts) on 10/19/12 and 10/20/12 in which immediate was clarified (as soon as you see it or suspect it and resident safety has been secured) as explained in the previous paragraph. The facility does not employ any agency staff. This information will be provided to new hires or any staff not included in the above education due to being on leave or unavailable by the Staff Development Coordinator (a		

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F 490 Continued From page 42
allegedly abused were not able to "voice concerns or issues". The DON stated she was unaware SRNA #4 had reported the abuse she had witnessed to RN #1 until 10/24/12 when the State Survey Agency reported their findings to the facility. She stated she was very disturbed when she learned of this information and RN #1 had been terminated.

Interview, on 10/15/12 at 10:20 AM, with the DON revealed there was a posting in the staff break room that indicated there was twenty-four (24) hours in which to report abuse. However, she stated she had made it clear that any sign of abuse was to be reported immediately to the Nurse in charge or the Supervisor. The DON stated she did not know why the posting was in the break room. She stated she could see where staff misunderstood the posting, however that was not what they were taught.

Interview, on 10/19/12 at 7:27 PM, with the Administrator revealed the posting which indicated a time of twenty-four (24) hours to report abuse had come from "Corporate", and it's use was to walk staff through how to report abuse themselves. He stated staff was told to report as soon as it (abuse) occurs and there was never anytime the facility would want them to delay reporting it.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 10/23/12 that alleged removal of the Immediate Jeopardy (IJ) on 10/21/12, based on the following:

1. All residents in the facility underwent skin assessments, starting 10/05/12, by Licensed

F 490 registered nurse) or the Assistant Director of Nursing (a registered nurse) prior to assuming any direct care assignment and before returning to work. All staff are re-educated on the abuse policy at a minimum twice a year by the Staff Development Coordinator utilizing Silver Chair, a computerized learning program, created especially for health care industries. Residents and/or the responsible party receive a copy of the facility abuse policy upon admission.

The Administrator, Director of Nursing (a registered nurse), Assistant Director of Nursing (a registered nurse) or the Staff Development Coordinator (a registered nurse) will conduct a total of 15 staff interviews per week for 8 weeks regarding the facility's abuse policy and aspects of resident abuse to ensure continued and thorough understanding of the policy. Any incorrect answers will be immediately addressed via 1:1 education. These interviews will

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F 490 Continued From page 43
Nurses.

2. All interviewable residents were interviewed regarding if they had experienced any form of mistreatment in the facility by the DON, ADON, Staff Development Nurse and Social Services Director. Responsible parties were notified of the abuse allegations starting on 10/05/12.

3. All facility staff received education on the facility Abuse Protocols on 10/19/12 and 10/20/12, by the DON, ADON and Staff Development Nurse. The education was all inclusive of the facility's abuse policies, with special emphasis on reporting immediately any suspected abuse. Immediately was clarified (as soon as you see it or suspect it and resident safety had been secured).

4. Additional education was provided to the Administrator, by the Continuous Quality director for Kentucky, related to the Resident Advocacy Protocols which included the correct abuse policy.

5. During staff interviews, conducted by the DON and ADON, it was identified that the Elder Abuse federally required posting in the employee break room stated that immediate reporting was required but identified the time frame as two (2) to twenty-four (24) hours. The posting was removed from the employee break room and placed in an alternate area, by the time clock on 10/19/12. This posting was identified as a possible root cause of timely reporting. All staff was educated on 10/19/12 and 10/20/12, by the DON, ADON and Staff Development Nurse, on the clear expectation of immediate reporting and immediate was clarified (as soon as you see it or

F 490

be conducted on all shifts and in all departments.

The Administrator, Social Services Director or the Activity Director will conduct Resident Council meetings on a weekly basis for four weeks to determine that residents feel safe in the facility and that the residents are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family members or visitors. Any concerns of this nature will be forwarded to the Administrator or DON.

The results of the Resident Council meetings and staff interviews will be discussed weekly in the facility Focus Interdisciplinary Team Meeting. This Focus Interdisciplinary Meeting meets every Thursday and is a sub-committee of the facility's Continuous Quality Improvement Committee. The members of this team include the Administrator, DON (a registered nurse), ADON (a registered

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F 490 Continued From page 44
suspect it and resident safety had been secured). New hires would be provided the education by the Staff development Nurse during orientation.

6. The Activities Director, Administrator and Social Services Director held a Resident Council Meeting on 10/22/12 to determine if residents felt safe. The Administrator, Social Services Director, or Activity Director will conduct Resident Council Meetings on a weekly basis for four (4) weeks to determine that residents feel safe and that residents are permitted and encouraged to express and report any concerns regarding behaviors displayed by staff, residents, family members or visitors. Any concerns will be forwarded to the Administrator or DON.

7. Results of the Resident Council Meetings will be discussed weekly in the facility Focus Interdisciplinary Team (IDT) meetings. The IDT meets every Thursday and is a sub-committee of the facility's Continuous Quality Improvement (CQI) Committee. Results of the IDT meetings will be forwarded to the CQI meeting the second Wednesday of every month.

8. The Administrator, DON, ADON, or Staff Development Coordinator will conduct a total of fifteen (15) staff interviews per week for eight (8) weeks regarding the abuse policy. The interviews are to be conducted on all shifts and in all departments.

9. Additional education was provided to the Administrator and DON regarding their duties and responsibilities for effective administering of the facility's Abuse Policies on 10/19/12 by the Continuous Quality Director for Kentucky.

F 490 nurse), MDS Coordinators (2 registered nurses and a licensed practical nurse), Staff Development Coordinator (a registered nurse), Medical Records Director, Activity Director and Social Services Director. The results will also be followed monthly in the facility Continuous Quality Improvement Committee (CQI) meeting which is held the second Wednesday of every month and consists of the above team members plus Housekeeping/Laundry Supervisor, and Maintenance Supervisor, Business Office Manager, and Dietary Manager. The Medical Director and Pharmacist also attend the CQI meeting quarterly, at a minimum. The members of the Focus Committee and CQI Committee will make recommendations regarding further monitoring and continued compliance.

F280
It is the policy of Wurland Nursing and Rehabilitation Center to develop a comprehensive plan

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F 490 Continued From page 45

10. Cell phone numbers of the Administrator, DON, and ADON were posted at each nurse's station on 10/06/12 and at the time clock on 10/07/12.

On 10/26/12, the State Agency verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AoC, effective 10/21/12, based on the following:

Interview, on 10/26/12 at 3:15 PM, with the DON revealed all facility residents had received a skin assessment after the abuse allegations were made. Record review of four (4) resident's records (Residents #9, #10, #11, and #12) revealed skin assessments had been performed.

Interview, on 10/26/12 at 3:15 PM, with the Director of Nursing (DON) revealed all interviewable residents in the facility had been interviewed on 10/20/12 related to how staff treated them, if they felt safe, and if they felt comfortable reporting issues. Interview, on 10/25/12 at 2:40 PM with Resident #8, at 2:45 PM, with Unsampled Resident A at 2:55 PM, and with Resident #7 at 3:08 PM, revealed they had been interviewed by facility staff recently related to how they were treated, if they felt safe, and if they were comfortable reporting issues.

Interview, on 10/18/12 at 11:25 AM, with an unsampled resident, and on 10/19/12 at varying times with eight (8) unsampled residents revealed no complaints of abuse or mistreatment by facility staff. Interview, on 10/18/12 at 6:25 PM, with Resident #6's responsible party revealed she had been informed of the abuse allegations.

F 490

of care within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, and to the extent practicable, the participation of the resident and/or the responsible party.

On 10/25/12, the MDS Coordinator, (a licensed practical nurse) updated the care plan for Resident # 12 indicating that oxygen is not in use. The MDS Coordinator (a licensed practical nurse) re-opened Resident #12's MDS on 10/26/12 and made the correction indicating oxygen was not in use. The MDS Coordinator (a licensed practical nurse) resubmitted this MDS on 10/30/12.

All active resident care plans were reviewed and revised as needed to ensure that they accurately reflect the individualized needs of each resident by 11/9/12 by an MDSC (2 registered nurses and 1 LPN). All care plans, including those for new admissions, will be updated daily (Monday-Friday) in

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185261	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/26/2012
NAME OF PROVIDER OR SUPPLIER WURLAND NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 WURLAND AVENUE WURLAND, KY 41144	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 400	<p>Continued From page 46</p> <p>Interview, on 10/18/12 at 6:40 PM, with Resident #4's responsible party revealed she had been informed of the abuse allegations. Interview, on 10/18/12 at 6:58 PM, with Resident #3's responsible party revealed she had been informed of the abuse allegations.</p> <p>Review of the Inservice records, dated 10/19/12 and 10/20/12 revealed all levels of facility staff, including Dietary, Housekeeping, and Laundry staff, received additional education on the facility's abuse policies with "immediate" being clarified. Interview, on 10/25/12 at 4:33 PM with Housekeeper #1; at 4:33 PM with SRNA #1; at 4:50 PM with LPN #6; at 4:56 PM with LPN #2; at 6:14 PM with SRNA #12, who all worked the 2:00 PM to 10:00 PM shift; and at 6:22 PM with SRNA #10 (who worked the 10:00 PM to 6:00 AM shift), revealed they had all received additional education on abuse which included clarification of "immediate".</p> <p>Interview, on 10/26/12 at 9:10 AM with Housekeeper #3; at 9:20 AM with LPN #5; at 9:20 AM with Housekeeper 2; at 9:27 AM with Dietary Aide #1; at 9:30 AM with Housekeeper #4; at 9:34 AM with Dietary Aide #2; at 9:40 AM with LPN #7; at 9:45 AM with Housekeeper #5; at 9:52 AM with SRNA #13; at 10:00 AM with Laundry Personnel #1; at 10:05 AM with Cook #1; at 10:10 AM with SRNA #14; at 10:25 AM with SRNA #15; at 10:50 AM with SRNA #16; at 11:03 AM with Valet #1; at 11:08 AM with SRNA #17 (who usually worked the 2:00 PM to 10:00 PM shift); at 11:10 AM with SRNA #23; at 11:20 AM with SRNA #18; at 11:25 AM with SRNA #19 and #24; at 11:33 AM with SRNA #20; at 11:35 AM with SRNA #22; at 11:45 AM with SRNA #21; at 12:55 PM with RN #1 (who</p>	F 490	<p>Morning Meeting by an MDSC (2 RN's and 1 LPN) to reflect any new or revised doctor orders.</p> <p>The Regional MDSC provided additional education to all MDS Coordinators (2 RN's and 1 LPN) on 11/6/12 regarding the care plan process, the importance of ensuring accuracy of care plans, ensuring care plans are current with special emphasis on the accuracy of appliances ordered for each resident as well as the RAI guidelines and facility policies regarding the process.</p> <p>The DON will audit 5 resident care plans per week for 4 weeks to ensure that the correct individualized needs are on record. Any revisions or re-education will be made at that time.</p> <p>The results of the audits will be discussed weekly in the facility Focus Interdisciplinary Team Meeting. This Focus Interdisciplinary Meeting meets every Thursday and is a sub-</p>

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(X4) ILL PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	III PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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worked the 10:00 PM to 6:00 AM shift); and at 2:20 PM with SRNA #26 (who worked the 10:00 PM to 6:00 AM shift), revealed they had all received additional education on abuse which included clarification of "Immediate".

Observation, on 10/26/12 at 2:15 PM, of the area surrounding the time clock revealed the federally required posting related to Elder Abuse was present. Additionally, the Administrator's, DON's, and ADON's phone numbers were also present in this area.

Interview, on 10/26/12 at 3:55 PM, with the Administrator revealed he had received education related to the correct abuse policy, and on administering the facility as per the AoC. The Administrator stated a Resident Council Meeting had been held that week, and would be held every week for four (4) weeks as per the AoC. He stated results of the Resident Council Meetings would be discussed weekly in the facility Focus Interdisciplinary Team (IDT) meetings. Results of the IDT meetings would be forwarded to the CQI meeting the second Wednesday of every month. In addition, he stated staff interviews were being conducted to ensure staff were knowledgeable of the Abuse policy. The Administrator stated a total of fifteen (15) staff interviews per week for eight (8) weeks regarding the abuse policy would be conducted.

Review of the Staff Abuse Questionnaire forms dated, 10/24/12, revealed the Administrator had conducted seven (7) staff interviews. Review of the Staff Abuse Questionnaire forms, dated 10/25/12, revealed the Administrator had conducted two (2) staff interviews.

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committee of the facility's Continuous Quality Improvement Committee. The members of this team include the Administrator, DON (a registered nurse), ADON (a registered nurse), MDS Coordinators (2 registered nurses and a licensed practical nurse), Staff Development Coordinator (a registered nurse), Medical Records Director, Activity Director and Social Services Director. The results will also be followed monthly in the facility Continuous Quality Improvement Committee (CQI) meeting which is held the second Wednesday of every month and consists of the above team members plus Housekeeping/Laundry Supervisor, and Maintenance Supervisor, Business Office Manager, and Dietary Manager. The Medical Director and Pharmacist also attend the CQI meeting quarterly, at a minimum. The members of the Focus Committee and CQI Committee will make recommendations regarding further monitoring and continued compliance.

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Interview, on 10/26/12 at 3:15 PM, with the Director of Nursing (DON) revealed she had been re-educated on the facility abuse policy and the administering of the facility by the Continuous Quality Improvement Director for Kentucky. She stated the Abuse policy given to the surveyors previously had been the incorrect one. She stated education was provided for all facility staff, and some staff interviews related to the education had been performed already that week. According to the DON, the staff interviews were to take place for eight (8) weeks, and if staff did not answer correctly they would receive a one on one education to ensure they were knowledgeable. In addition, she stated a Resident Council Meeting had been held earlier in the week, and if there were nursing issues she or the Assistant Director of Nursing (ADON) would be notified so they could decide what needed to be done.

Interview, on 10/26/12 at 4:20 PM, with the Continuous Quality Improvement Director for Kentucky revealed she had re-educated the Administrator and DON on the correct facility Abuse policy.

The facility remained out of compliance at a lower Scope and Severity of a "D", an Isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).

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Wurland Nursing and Rehabilitation Center is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as specified in 483.75.

The Regional Continuous Quality Improvement Nurse (a registered nurse) provided education to the Administrator and Director of Nursing (a registered nurse) regarding duties and responsibilities for effective administering of the facility Abuse Policies on 10/19/12.

Administrator duties include:

- Organizes the functions of the facility through appropriate departmentalization and delegation.
- Implements the control and effective utilization of

the physical and financial resources of the facility.

- Development and implementation of policies/procedures to ensure a safe, efficient, high quality service is provided.
- Reviews and acts upon the reports of authorized inspecting agencies.
- Employs a system of responsible accounting.
- Provides an effective public relations program.
- Recruits, selects and retains department managers.
- Manages and directs day to day operations of facility
- Conducts daily stand-up meeting
- Attends nursing report
- Reviews and signs incident reports
- Conducts department manager meetings.
- Facility rounds daily
- Attends weekly focus

meetings.

- Chairs monthly CQI meeting
- Meets with physician, family, residents as needed
- Conducts monthly family meetings
- Complete abuse investigations and ensures appropriate reporting
- Ensures effective communication within facility

The Administrator initiated, implemented and continues to review, on a daily basis (Monday through Friday), the monitoring and implementation of the above listed plan for abatement of the immediate jeopardy. This is accomplished by being a participating member of the Administrative Team, daily review of nursing supervisor reports, daily physical rounds in facility, daily review of 24 hour nursing communication sheet, daily review of incident reporting,

and daily interaction with employees and staff.

In the absence of the Administrator, the Director of Nursing (a registered nurse) will assume the responsibility in their place until the Administrator is able to return.

Any alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property must be reported to the Administrator immediately (as soon as it is reported or suspected) via phone call or in person. If the Administrator is unavailable, the DON (registered nurse) or ADON (a registered nurse) will be notified in person or via phone. Cell phone numbers of these individuals are posted at each nurses station and at the time clock. If an allegation of abuse is directed at the Administrator, the employee is to call the Employee Compliance Line at 1-888-508-9774. All reports will be thoroughly

investigated.

Weekly, each Wednesday, the facility Medical Director will review any allegations of resident abuse. He will provide input and recommendations to ensure the continued safety of our residents.

The monitoring of the above noted process will be conducted by the Regional Area Administrator monthly for 3 months. The Regional Area Administrator will also conduct 5 staff interviews twice weekly for 8 weeks to ensure continued understanding of the meaning of immediate as (as soon as you see it or suspect it and resident safety has been secured) and continued understanding of the facility's abuse policy. Any incorrect answers will be immediately addressed via 1:1 education.

The facility has engaged the services of an independent contractor to provide Compassionate and Person Centered Training to the facility's

direct care staff and facility administration. The facility does not employ any agency staff. The independent contractor we have retained is:

Barbara W. Stoll, BSW,
MS, ACC
Stoll Health Care
Consulting Services, Inc.
P.O. Box 701934
Saint Cloud, Florida,
34770-1934
stollhccs@aol.com
Office: 407-892-9054
Fax: 407-892-1882

The contractor will forward a written report to CMS and the State providing the content of the training, documentation of objectives and attendees participating. During the course of the training the independent contractor and governing body (the Director of Nursing, Administrator, Medical Director, Regional Area Administrator, Regional Continuous Quality

Improvement Nurse, and Regional Vice President) shall develop a mission statement that reflects a commitment to maintaining and improving quality for Medicare beneficiaries. All training will be completed on or before December 1, 2012.

The independent contractor will evaluate the skills and competency of direct care staff and facility administration on their ability to provide compassionate, person centered care. The contractor shall submit a written report to CMS and the State summarizing the outcomes of the competency skills evaluation of all staff required to take this training. Of particular importance is staff knowledge related to abuse and neglect. This evaluation process will be completed on or before December 1, 2012.

The independent contractor will conduct training for the governing body (the Director of Nursing,

Administrator, Medical Director, Regional Area Administrator, Regional Continuous Quality Improvement Nurse, and Regional Vice President) and all facility personnel on how to create and maintain a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect. This training will be completed on or before December 1, 2012.

The training provided by the independent contractor shall include a discussion of all types of abuse including but not limited to domestic abuse, institutional abuse and neglect, physical abuse, sexual assault, misuse of restraints, chemical restraints, physical restraints, emotional, psychological/verbal abuse, physical neglect, medical neglect, abandonment, and financial or material exploitation.

The facility will provide written information on how to report elder abuse for all employees and

facility administration on or before December 1, 2012. The facility does not employ any agency staff. The independent contractor shall also provide information to residents during a resident council meeting on abuse on or before December 1, 2012. A family council meeting will also be conducted by the independent contractor on a weekday (Thursday, November 29, 2012 at 7:00 p.m.) and a weekend (Saturday, December 1, 2012 at 10:00 a.m.) to discuss abuse and reporting with family members. All information regarding how to report abuse will be readily available on request. Training shall include a review of the requirements for reporting reasonable suspicion of a crime in a Long Term Care Facility (LTC) in accordance with S&C: 11-30-NH.

CMS and the State survey agency will be provided a signed and notarized attestation statement from the facility administrator verifying training has been

provided to all staff on or before
December 1, 2012. The facility
does not employ any agency staff.