

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

PRINTED: 01/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/31/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD WINCHESTER, KY 40391</b>
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F 000 INITIAL COMMENTS

F 000

An Abbreviated/Partial Extended Survey investigating KY00022603 and KY00022608 was initiated on 12/22/14 and concluded on 12/31/14. KY00022608 was unsubstantiated with no deficiencies. KY00022603 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 12/24/14 and determined to exist on 12/13/14 in the areas of 42 CFR 483.10 Resident Rights, F157; 42 CFR 483.13 Resident Behavior and Facility Practice F223, F225 and F226; and 42 CFR 483.20 Resident Assessment F280, all at a Scope and Severity (S/S) of a "J". Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practice, F223, F225 and F226. The facility was notified of the Immediate Jeopardy on 12/24/14.

Interview and record review revealed Resident #1 had a history of exhibiting sexual behaviors towards residents and staff, including touching female breasts and buttocks. On 12/13/14 at 11:15 AM Housekeeper #1 and Housekeeper #2 witnessed Resident #1 touching Resident #2 on his/her thigh between the legs. The housekeepers informed State Registered Nurse Aide (SRNA) #1, who separated the residents and informed Registered Nurse (RN) #4/Weekend Supervisor of the observed incident. RN #4 instructed RN #3/Charge Nurse to have Housekeeper #1 and Housekeeper #2 provide written witness statements. Although Resident #1 and Resident #2 were separated, no physical assessment was completed for Resident #2; there was no documented evidence the facility implemented increased supervision of Resident #1; and, information concerning the incident was not passed on to subsequent shifts, verbally or in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F 000 : Continued From page 1  
writing to protect the residents.

F 000 :

On 12/14/14 RN #1 heard Resident #2 talking about being touched. As RN #1 had not received any report of the incident on 12/13/14, she assumed Resident #2 was speaking about something that happened in the past. RN #1 failed to report the concerns voiced by Resident #2. On 12/15/14, Resident #1 touched Resident #2 again. Resident #2 yelled out, pointed a finger at Resident #1, and stated Resident #1 had touched his/her breast and was "naughty" for doing so.

An acceptable credible Allegation of Compliance (AOC) was received on 12/29/14. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected on 12/20/14 prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

F 157 : 483.10(b)(11) NOTIFY OF CHANGES  
SS=J (INJURY/DECLINE/ROOM, ETC)

F 157 :

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of

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F 157 Continued From page 2  
treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's policy and incident reports, it was determined the facility failed to have an effective system in place to ensure residents' Physicians and Responsible Parties were notified of an alleged sexual abuse incident for two (2) of five (5) sampled residents (Resident #1 and Resident #2). (Refer to F223)

Interview and record review revealed Resident #1 had a history of exhibiting sexual behaviors towards residents and staff, including touching female breasts and buttocks.

On 12/13/14 at 11:15 AM Housekeeper #1 and Housekeeper #2 witnessed Resident #1 touching Resident #2 on his/her thigh between the legs. The housekeepers informed State Registered Nurse Aide (SRNA) #1, who separated the

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Past noncompliance: no plan of correction required.

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F 157	<p>Continued From page 3</p> <p>residents and informed Registered Nurse (RN) #4/Weekend Supervisor of the observed incident. RN #4 instructed RN #3/Charge Nurse to have Housekeeper #1 and Housekeeper #2 provide written witness statements. Although Resident #1 and Resident #2 were separated, no physical assessment was completed for Resident #2; there was no documented evidence the facility implemented increased supervision of Resident #1; and, information concerning the incident was not passed on to subsequent shifts, verbally or in writing to protect the residents.</p> <p>On 12/14/14 RN #1 heard Resident #2 talking about being touched. As RN #1 had not received any report of the incident on 12/13/14, she assumed Resident #2 was speaking about something that happened in the past. RN #1 failed to report the concerns voiced by Resident #2. On 12/15/14, Resident #1 touched Resident #2 again. Resident #2 yelled out, pointed a finger at Resident #1, and stated Resident #1 had touched his/her breast and was "naughty" for doing so.</p> <p>Furthermore, even though nursing staff were notified of the alleged abuse on 12/13/14 and overheard Resident #2 discussing being touched by a male resident on 12/14/14, they failed to ensure Resident #1's and Resident #2's Physician and Responsible Parties were notified of this information.</p> <p>The facility's failure to have an effective system to ensure residents' Physicians and responsible parties were notified of potential sexual abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/24/14 and was determined to</p>	F 157		
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F 223 Continued From page 45  
18) Review of the QA minutes for the weekly meetings dated 12/15/14, 12/19/14 and 12/24/14 revealed the Plan of Action for the cited deficiencies was discussed each time. Any changes to the QA Plan of Action were to be in bold print. No changes were made during these weekly meetings. Interview with the Administrator, on 12/31/14 at 10:20 AM, revealed if any changes were determined to be necessary, they would be reviewed by the entire QA team and communicated to facility staff. Continued interview with the Administrator revealed the QA weekly committee meetings consisted of all Department Heads, Unit Managers, Chaplain, Medical Director, Social Worker, Dietitian, Administrator and DON.

F 223

F 225  
SS=J 483.13(c)(1)(ii)-(iii), (c)(2) - (4)  
INVESTIGATE/REPORT  
ALLEGATIONS/INDIVIDUALS

F 225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law

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F 225 Continued From page 46 through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of facility policy and incident report, it was determined the facility failed to have an effective system to ensure all allegations of abuse were reported immediately and investigated thoroughly for one (1) of five (5) sampled residents (Resident #2). (Refer to F223)

Interview and record review revealed Resident #1 had a history of exhibiting sexual behaviors towards residents and staff, including touching female breasts and buttocks. On 12/13/14 at 11:15 AM Housekeeper #1 and Housekeeper #2 witnessed Resident #1 touching Resident #2 on his/her thigh between the legs. The housekeepers informed State Registered Nurse Aide (SRNA) #1, who separated the residents and informed Registered Nurse (RN) #4/Weekend Supervisor of the observed incident.

F 225

Past noncompliance: no plan of correction required.

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F 225 Continued From page 47

RN #4 instructed RN #3/Charge Nurse to have Housekeeper #1 and Housekeeper #2 provide written witness statements. Although Resident #1 and Resident #2 were separated, no physical assessment was completed for Resident #2; there was no documented evidence the facility implemented increased supervision of Resident #1; and, information concerning the incident was not passed on to subsequent shifts, verbally or in writing to protect the residents.

On 12/14/14 RN #1 heard Resident #2 talking about being touched. As RN #1 had not received any report of the incident on 12/13/14, she assumed Resident #2 was speaking about something that happened in the past. RN #1 failed to report the concerns voiced by Resident #2. On 12/15/14, Resident #1 touched Resident #2 again. Resident #2 yelled out, pointed a finger at Resident #1, and stated Resident #1 had touched his/her breast and was "naughty" for doing so.

The facility's failure to ensure an allegation of abuse on 12/13/14 was reported and thoroughly investigated was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/23/14, and was determined to exist on 12/13/14. The facility was notified of the Immediate Jeopardy on 12/24/14.

An acceptable credible Allegation of Compliance (AOC) was received on 12/29/14. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected on 12/20/14 prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

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F 225	Continued From page 48	F 225		
	<p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect and Misappropriation", effective date 04/2013, revealed allegations of abuse were to be reported immediately to the Charge Nurse, who was to report immediately to the Administrator or Director of Nursing and/or the Abuse Coordinator. In addition, if the DON or Administrator were not present at the facility, they were to be contacted by phone. Further review of the policy revealed all allegations of abuse were to be investigated.</p> <p>Review of the facility's policy titled "Accidents and Incidents-Investigating and Reporting", not dated, revealed all accidents or incidents involving residents occurring on the premises were to be investigated and reported to the Administrator. Continued review revealed the Nurse Supervisor, Charge Nurse, Department Director or Supervisor was to promptly initiate and document an investigation of the incident or accident on the Report of Incident/Accident form. Further review of the policy revealed the completed form was to be submitted to the Director of Nursing Services (DNS) within 24 hours of the incident or accident, and the DNS was responsible to ensure the Administrator received a copy of the Report of Incident/Accident form for each occurrence.</p> <p>Interview with Housekeeper #1, on 12/24/14 at 12:15 PM, and Housekeeper #2, on 12/24/14 at 3:31 PM, revealed they were in the hall at 11:15 AM on 12/13/14, and saw Resident #1 touch Resident #2 between the legs. They informed SRNA #1, and provided a written statement for RN #3.</p> <p>Interview with SRNA #1, on 12/23/14 at 3:30 PM,</p>			

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F 225 Continued From page 49

revealed on 12/13/14 at approximately 11:15 AM, Housekeepers #1 and #2 reported to her they saw Resident #1 touch Resident #2 on the inner thigh area. She stated she informed RN #4 of the housekeepers' observation. She further stated she was not asked for a formal statement until 12/16/14, three (3) days after the incident.

Telephone interview with RN #4, on 12/24/14 at 2:50 PM, revealed Housekeepers #1 and #2 witnessed Resident #2 touch Resident #1 between the legs. He asked RN #3 to take a written statement from the housekeepers related to what they had witnessed. RN #4 further stated he placed the written statements on the Unit Manager's desk. Continued interview revealed RN #4 expected RN #3 would notify the DON immediately.

Telephone interview with RN #3, on 12/24/14 at 3:00 PM, revealed on 12/13/14 Housekeepers #1 and #2 reported Resident #1 touched Resident #2 between the thighs. She stated she took the housekeepers' written statements and gave them to RN #4. Continued interview revealed she thought RN #4, who was the Supervisor, would contact the DON. She further stated she was the Charge Nurse for the unit where the incident occurred, but did not realize as Charge Nurse she should have contacted the DON immediately.

Interview with RN #1, on 12/23/14 at 2:57 PM, revealed she overheard Resident #2 having a conversation with his/her family on 12/14/14, and heard Resident #2 say Resident #1 "touched" him/her. RN #1 stated she assumed Resident #2 was speaking of something from the past, as the resident had a history of speaking of past events. Per interview, RN #1 did not report the

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F 225

Continued From page 50 allegation.

F 225

Review of the Nurses Notes for Resident #2, for the dates of 12/13/14 and 12/14/14, revealed no documentation of the resident's allegation of abuse. In addition, there was no documented evidence of an assessment or interview, or any investigation being initiated.

Review of the Incident Report, dated 12/15/14 at 8:00 AM, revealed Resident #2 alleged Resident #1 touched him/her on the breast while sitting in the lobby of the Cherry Blossom Unit.

Review of the State Survey Agency Intake Form revealed the facility submitted their initial report of the allegation of abuse on 12/15/14. Continued review revealed the facility sent additional information on 12/16/14 which indicated there had been another incident on 12/13/14, when Resident #1 "touched" Resident #2. Continued review of the Intake Form, including the initial and final reports by the facility, revealed no documented evidence of any investigation of the incident on 12/13/14 prior to the allegation of abuse made on 12/15/14.

Interview with the DON, on 12/31/14 at 10:10 AM, revealed she was not aware of the incident on 12/13/14 until after the incident on 12/15/14 was reported. She stated it was her expectation that staff follow the facility's Abuse Policy and immediately report any allegation of abuse, or signs and symptoms of abuse, to the Charge Nurse. She further stated she expected the allegation be immediately reported to the DON or the Administrator so an investigation could be initiated.

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F 225	<p>Continued From page 51</p> <p>A post-survey interview with the Administrator on 01/15/15 at 11:25 AM, revealed the facility's policy regarding allegations of abuse was for staff to report the alleged abuse to their Charge Nurse. Per interview, the Charge Nurse was to call the DON, Administrator, Abuse Coordinator and Social Services (SS). The Administrator stated after the incident on 12/13/14 was reported to the Charge Nurse and she informed the Weekend Supervisor, one (1) of them should have followed the policy and notified her, the DON, Abuse Coordinator and SS. According to the Administrator, the Charge Nurse did not fully inform the Weekend Supervisor of what had occurred, but she would have expected him to have gotten the specifics. She stated if the appropriate reports and documentation had been completed, "some type of follow up could have been done". She further stated it was possible had she been notified on 12/13/14, the incident on 12/15/14 "might not have occurred". The Administrator stated the facility determined their system had failed on 12/13/14, when the Charge Nurse reported the incident to the Weekend Supervisor but did not follow up.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/29/14, which alleged removal of the IJ effective 12/20/14. Review of the AOC revealed the facility implemented the following corrective actions:</p> <p>1) The allegation of resident to resident inappropriate touching on 12/13/14, was reported to the State Survey Agency, the Physician and the Power of Attorney (POA) for both residents on 12/16/14. A thorough investigation was initiated on 12/15/14 and concluded on 12/19/14 by the Administrator, the DON and Social Services. A</p>	F 225		

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F 225	<p>Continued From page 52</p> <p>five (5) day report was sent to the State Survey Agency and Adult Protective Services on 12/19/14. The Comprehensive Care Plans for Residents #1 and #2 were updated with appropriate interventions to meet each resident's care needs on 12/15/14 by the DON, Nursing Supervisors, or MDS Coordinator. Resident #2 was assessed on 12/15/14 by the Charge Nurse with no concerns noted. One to one (1:1) education was provided to RN #4 and RN #3 by the Administrator and the Regional Nurse Consultant by 12/19/14. Resident #1 was placed on 1:1 observation when out of bed and every fifteen (15) minute checks while in bed and a consult for psychiatric services was initiated. Social Services was consulted for follow-up with Resident #2 for psychosocial support and to identify any concerns for Resident #2.</p> <p>2) All residents were assessed for any signs and symptoms of abuse/neglect. Residents with a BIMS score &gt;8 were interviewed by the Social Services Director, Chaplain, Registered Dietitian, Human Resources, Environmental Director, Unit Managers, Nursing Supervisors, Admissions personnel, Restorative Nurse, Physician's nurses or the Administrator for any abuse/neglect concerns on 12/15/14. Residents with a BIMS score &lt;8 were physically assessed by the nursing supervisors for any signs and symptoms of abuse/neglect. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator or the Regional Nurse Consultant (RNC) on 12/16/14 for any indications of abuse/neglect. No concerns were identified.</p> <p>3) All resident charts were reviewed for any status changes in the past thirty (30) days by the DON,</p>	F 225		
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Nursing Supervisors, Unit Manager, Staff Development Coordinator (SDC), MDS staff, Medical Records personnel, Marketing/Admissions personnel, Social Service Director (SSD) or the RNC by 12/17/14 to ensure Physician and POA notifications were made and care plans were updated appropriately to reflect current resident care needs. No issues were identified.

4) Re-education on implementation of the Abuse Policy was provided by the Regional Nurse Consultant on 12/15/14 and 12/16/14 for the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, Recreational Staff Manager, Medical Records, Human Resources, and designated charge nurses. Educational topics included: performing a thorough investigation; immediate reporting; updating the care plans according to facility policy; review of the policy related to accidents and incidents; review of the 24 Hour Report Policy; and notification of Physicians and family. The training was face-to-face to facilitate discussion. Examples of reportable incidents were discussed and a written post-test was administered. Those educated could not return to work until 100% score on the post-test was achieved.

5) After re-education by the RNC, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Services Manager, Medical Records personnel, and designated Charge Nurses were

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assigned to re-educate all staff. This education was initiated on 12/15/14 and completed on 12/19/14. Any staff who were on leave or had not completed the education by 12/19/14 was sent a certified letter informing them they could not return to work until they received the training. Each staff member was required to score 100% on the written post-test prior to returning to work. In addition, all newly-hired staff will be required to complete abuse training and score 100% on the post-test before beginning their job duties.

6) Beginning 12/15/14, post-tests will be administered to ten (10) different staff daily, to include all shifts. Two (2) different tests will be utilized on alternating days to ensure ongoing retention and understanding of the provided abuse education. The tests will be administered by the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Environmental Services Director or Human Resources staff.

7) Human Resources personnel will audit all new employees hired since 10/22/14 for any abuse concerns. A total of twenty (20) new employees were reviewed. Audit results were reviewed by the RNC, Clinical Compliance Nurse or the Vice President of Operations on 12/17/14. No concerns were identified.

8) All grievances dated 11/15/14 to 12/15/14, and all new grievances beginning on 12/16/15 were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors or Regional Nurse Consultant to ensure all reportable allegations had been

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identified. A total of forty-one (41) grievances were reviewed.

9) All incident reports from 11/15/14 to 12/15/14 were reviewed by the DON, Assistant DON, SDC or RNC on 12/16/14 to identify any concerns of suspected neglect. A total of fifty-nine (59) reports were reviewed and no concerns were identified.

10) Beginning 12/15/14, a nurse from the regional team or corporate office will be onsite daily until the IJ is lifted. The nurses will assist with investigations, observations of staff treatment of residents, perform chart audits and provide oversight and consultation.

11) The Administrator, DON, Nursing Supervisors and Department Heads will be onsite daily and make walking rounds of the facility. Five (5) residents with a BIMS score >8 will be interviewed and five (5) residents with a BIMS score <8 will be physically assessed for abuse concerns. In addition, staff assigned to the residents will be questioned regarding any behavioral changes exhibited by the residents. This will continued until the IJ is lifted. Then, three (3) residents with a BIMS score >8 and three (3) resident with a BIMS score <8 will be interviewed or assessed daily for four (4) weeks. All results will be reported at the weekly Quality Assurance (QA) meeting. At the end of the four (4) weeks, the QA committee will determine at what frequency the interviews, assessments and staff questionnaires need to continue. Any concerns identified will be addressed immediately, reported to the Administrator and an investigation initiated.

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12) Beginning 12/16/14 and continuing until the IJ is lifted, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, or Human Resources will be on site daily to complete the Resident Status Monitoring Form. Completion of the form requires staff interviews, review of the 24 hour sheet, observations for documented behaviors, walking rounds with visualization of all residents, identification of any reportable incidents and reporting to the Charge Nurse and Administrator for any identified incidents. Also, the DON will daily review Physician orders to ensure appropriate notifications are made and care plans are updated, review the 24 hour sheets for any resident status changes, review ten (10) resident charts for any status changes without appropriate notifications and care plan updates, and initiate reporting and investigation of any accidents/incidents that are reported. All results will be reported at the weekly QA meeting. After removal of the IJ, the committee will determine at what frequency the Resident Status Monitoring form needs to be completed.

13) Beginning 12/15/14, the Administrator, DON, and Social Services or a member of the regional staff will review all resident interviews, assessments and staff questionnaires daily for any concerns, and initiate an investigation as indicated.

14) The Administrator, DON, and Social Services Director will review and discuss all abuse investigations daily, starting on 12/15/14, to ensure that the resident is protected, the

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perpetrator is removed from the resident care area, reports to the State Survey Agency are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log, and along with regional staff will review the log daily to ensure the above.

15) In the event of any new report of alleged abuse, neglect or misappropriation of property, the regional office will be notified within twenty-four (24) hours and again at the conclusion of the investigation to ensure a thorough investigation is completed and reporting timelines are met.

16) During Care Plan conferences with residents and families, abuse/neglect concerns will be discussed. In addition, education related to abuse, including reporting, will be provided with supporting documentation.

17) Beginning 12/15/14, administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of the regional staff daily until removal of the IJ, then weekly for four (4) weeks, then monthly.

18) Beginning 12/15/14, a QA meeting will be held weekly until the IJ is removed, then for four (4) more weeks, then monthly. During these meetings, the QA committee will review and evaluate the stated plan, make recommendations for plan revisions or re-education needs as identified, and determine at what frequency ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being as well as an effective plan to identify

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facility concerns and implement a plan of correction to involve all facility staff.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1) Review of the State Agency Intake form revealed the initial facility report was received on 12/15/14 with additional information provided on 12/16/14. Continued review revealed the facility submitted a final report of their investigation on 12/19/14.

Review of two (2) Incident Reports, one for Resident #1 and one for Resident #2, revealed the Physician and the POA for each resident were notified by the facility on 12/15/14.

Review of the Comprehensive Care Plan for Resident #1 revealed it was updated on 12/15/14 to include the following interventions: 1:1 observation of the resident when out of bed, with every fifteen (15) minute checks while in bed; consult to Psychiatric Services; and a medication review.

Review of the Comprehensive Care Plan for Resident #2 revealed revised interventions included: report changes in mood status to the Physician; support the resident's strengths and coping skills; and encourage expression of feelings.

Review of the Nurses Note dated 12/15/14 at 9:00 AM, revealed Resident #2 was assessed by the Charge Nurse with no signs of physical contact, bruising, redness or swelling identified.

Interview with the DON, on 12/24/14 at 4:15 PM,

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revealed RN #4 and RN #3 received 1:1 education on 12/15/14 related to their responsibilities when abuse was alleged. Review of education records revealed both nurses did receive the training and had completed post-tests with a 100% passing score.

Review of the Resident Monitoring Tool for the dates of 12/15/14 through 12/30/14 revealed Resident #1 was on 1:1 observation when out of the bed, and every fifteen (15) minute observations were made when the resident was in bed.

Further review of the Comprehensive Care Plan for Resident #1 revealed a consult was placed with the facility's contracted Psychiatric Services.

Review of Social Services notes, dated 12/15/14 through 12/19/14, revealed Residents #1 and #2 were followed daily. Discussion with Resident #1 included education related to inappropriate behaviors and ongoing support for the resident and the spouse. Resident #2 was assessed daily for mood changes. The Social Worker documented no psychosocial concerns were identified for either resident.

2) Review of the facility's AOC binder, which contained documents related to the corrective actions, revealed all residents were assessed for signs and symptoms of abuse/neglect on 12/15/14. Residents with a BIMS score >8 were interviewed related to any abuse/neglect concerns by the Social Services Director, Chaplain, Registered Dietitian, Unit Managers and Nursing Supervisors. Residents with a BIMS score <8 were physically assessed for any signs or symptoms of abuse by the Nursing

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Supervisors. A review of the audits, assessments, and interviews utilized revealed not identified concerns.

Interview with he Administrator on 12/31/14 at 10:30 AM revealed she reviewed all of the resident interviews and assessments on 12/16/14 with no concerns identified.

3) A review of chart audit records revealed all resident records were reviewed for falls, behaviors, accidents, abuse, Physician orders, 24 hour reports, and notifications of the Physician, POA or family for any resident status change by 12/17/14. No concerns were identified.

4) Review of training records revealed the Administrator, DON, Nursing Supervisors, MDS Coordinator, Staff Development Coordinator, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Human Resources staff, and designated Charge Nurses were re-educated beginning on 12/15/14 and completed on 12/16/14 by the Regional Nurse Consultant. Topics covered included the Abuse Policy, investigations, care planning, notification of the Physician and family, and utilization of the 24 hour report to inform of a change in a resident's condition. Further review of documentation revealed all completed the post test with a 100% score.

Interviews with thirteen (13) administrative staff, including the Dietary Manager on 12/30/14 at 12:10 PM, the Registered Dietitian on 12/30/14 at 12:00 PM, the Director of Plan Operations on 12/30/14 at 3:00 PM, the SSD on 12/30/14 at

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F 225	<p>Continued From page 61</p> <p>3:15 PM, Social Worker #2 on 12/30/14 at 3:30 PM, Charge Nurse #3 on 12/31/14 at 8:30 AM, Charge Nurse #2 on 12/31/14 at 9:15 AM, Unit Manager #1 on 12/31/14 at 9:15 AM, the DON on 12/31/14 at 10:30 AM, the Administrator on 12/31/14 at 10:45 AM, the SDC on 12/31/14 at 12:40 PM, the Chaplain on 12/31/14 at 1:00 PM and the Rehabilitation Manager on 12/31/14 at 1:00 PM revealed all were re-educated on performing a thorough investigation, reporting, updating care plans, the facility policy on incidents and accidents, the 24 hour report policy and notifications by the Regional Nurse Consultant and completed a post-test.</p> <p>5) Further review of training records revealed all facility staff was re-educated on the facility's Abuse Policy, including identification and reporting, between 12/15/14 and 12/19/14. The training was provided by the DON, Administrator and the SDC.</p> <p>Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed Practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational Therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS</p>	F 225		
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Coordinator on 12/31/14 at 10:10 AM revealed all received re-education by the DON, SDC, Administrator and Charge Nurses on identifying, reporting and investigating abuse. In addition, all interviewees stated they were required to complete the post-test with 100% accuracy prior to returning to work.

Review of the Certified letter revealed it was sent on 12/19/14 to all PRN (as needed) staff and all staff on vacation or medical leave. The letter informed the recipient to contact the DON or the SDC to complete mandatory in-services prior to their next shift.

6) Review of post-tests dated 12/15/14 -12/30/14 revealed ten (10) facility staff were receiving rotating tests daily. All completed tests were scored at 100%.

Interview with the DON, on 12/31/14 at 10:30 AM, revealed she coordinated with the Administrator, SDC and nursing Unit Managers for continuing staff education related to the abuse policy.

Interview with the Registered Dietitian, on 12/30/14 at 12:00 PM, revealed the department managers were responsible for administering abuse quizzes to assigned staff.

Interview with the Dietary Manager, on 12/30/14 at 12:10 PM, revealed she had an assigned day for assessing staff knowledge about abuse.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational

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therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed they had received two (2) to three (3) quizzes per week to assess their retention and understanding of the information provided during the initial in-service.

7) A review of the Human Resources audit forms revealed twenty (20) newly hired staff since 10/22/14 were reviewed for any abuse concerns. The audits included a re-check of the Nurse Aide Abuse Registry to ensure no staff appeared on the Registry. Audit results were signed and dated as reviewed by the RNC on 12/17/14. No concerns were identified.

8) Review of the AOC binder revealed forty-one (41) grievances, dated 11/15/14 to 12/15/14, were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors, Regional Nurse Consultant on 12/16/14 with no concerns. Interview with the Administrator on 12/31/14 at 10:50 AM confirmed she had reviewed the grievances and that the grievances were continually reviewed daily from 12/16/14 to 12/30/14 to identify any reportable allegations which were not identified on the initial review.

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9) Review of AOC binder revealed fifty-nine (59) incident reports, dated 11/15/14 to 12/15/14, were reviewed by the DON, Assistant Director of Nursing, Staff Development Coordinator and Regional Nurse consultant with no concerns identified.

10) Review of the daily sign off sheets, dated 12/15/14 -12/31/14 revealed the Regional Nurse Consultant was present daily at the facility.

11) Record review of walking rounds documentation, dated 12/15/14 to 12/30/14, revealed they were completed daily by the Administrator, DON, Nursing Supervisors, and Department Heads. The rounds included a physical assessment by the nurse for five (5) residents with a BIMS score <8, and interviews with five (5) residents with a BIMS score >8, concerning how the residents were treated by facility staff. In addition, nurses and SRNA's were interviewed regarding any changes in resident behaviors. Review of the QA meeting minutes revealed all results of resident and staff interviews, and skin assessments, were discussed during the weekly QA meetings.

12) Review of the Resident Status Monitoring Forms revealed they were completed daily by the Administrator, DON and Department Heads during walking rounds. The form included staff interviews, review of the 24 Hour Report sheet, observations of residents for documented behaviors, and identification of reportable incidents with evidence of a report to administration. Continued review revealed the DON conducted a follow-up daily to ensure Physician orders and ten (10) resident records were reviewed daily to ensure appropriate

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F 225	<p>Continued From page 65</p> <p>notifications and care plan revisions were made. The audits were reviewed, signed and dated daily by the Administrator.</p> <p>13) Review of the AOC binder revealed it contained documented evidence the Administrator, DON, Social Services and RNC reviewed all resident interviews, assessments, and staff questionnaires daily between 12/15/14 and 12/31/14, with no identified concerns.</p> <p>14) Review of Abuse Log forms, dated 12/15/14-12/31/14, revealed the Administrator, DON and Social Service Director reviewed abuse allegations daily to track and trend for any additional needed interventions by the QA committee. All allegations were reviewed to ensure protection of residents by removal of the perpetrator, timeliness of reporting to the State Survey Agency, and initiation and completion of thorough investigations. Interview with the Administrator on 12/31/14 at 11:10 AM confirmed she would reviewed the abuse investigations and there were no new abuse allegations made during this period.</p> <p>15) Review of the Abuse Log and review of documented daily walking rounds of the Administrator, DON and Department Heads, from 12/15/14 to 12/30/14, revealed no new abuse allegations or incidents suspicious for abuse were identified.</p> <p>16) Review of the AOC binder and interview with the DON, on 12/31/14 at 1:00 PM, revealed no care plan conferences had taken place between 12/16/14 and 12/31/14. The DON stated the facility's plan for care plan conferences included discussion with the resident and/or family</p>	F 225		

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F 225 Continued From page 66 regarding any concerns they had about abuse. In addition, the DON stated during the meetings, education would be provided related to abuse, e.g. what abuse is and how to report abuse.

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17) Review of the daily tracking form dated 12/16/14-12/30/14 revealed administrative oversight was provided by the RNC, onsite daily throughout the period.

18) Review of the QA minutes for the weekly meetings dated 12/15/14, 12/19/14 and 12/24/14 revealed the Plan of Action for the cited deficiencies was discussed each time. Any changes to the QA Plan of Action were to be in bold print. No changes were made during these weekly meetings. Interview with the Administrator, on 12/31/14 at 10:20 AM, revealed if any changes were determined to be necessary, they would be reviewed by the entire QA team and communicated to facility staff. Continued interview with the Administrator revealed the QA weekly committee meetings consisted of all Department Heads, Unit Managers, Chaplain, Medical Director, Social Worker, Dietitian, Administrator and DON.

F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

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Based on interview, record review and review of facility policy it was determined the facility failed to implement its Abuse Policy regarding an allegation of resident to resident abuse for two (2) of five (5) sampled residents. (Refer to F223 and F225)

Interview and record review revealed Resident #1 had a history of exhibiting sexual behaviors towards residents and staff, including touching female breasts and buttocks. On 12/13/14, Resident #1 was observed sitting in his/her wheelchair and touching Resident #2 on the thigh between his/her legs. Facility staff witnessed the alleged abuse and witness statements were given to the Weekend Supervisor, Registered Nurse (RN) #4; however the nurse did not contact the Director of Nursing (DON) or the Administrator, the Physician or family of either resident, or the State Survey Agency. In addition, the facility failed to complete a physical assessment of Resident #2, provide close supervision of both residents, or update the Comprehensive Care Plans as directed by the Abuse Policy. Furthermore, the facility did not initiate an investigation of the incident until another incident occurred on 12/15/14.

The facility's failure to ensure policy and procedures related to abuse were implement was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/23/14, and was determined to exist on 12/13/14. The facility was notified of the Immediate Jeopardy on 12/24/14.

An acceptable credible Allegation of Compliance (AOC) was received on 12/29/14. Based on the validation of the AOC, the State Survey Agency

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Past noncompliance: no plan of correction required.

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determined the deficient practice was corrected on 12/20/14 prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

The findings include:

Review of facility's policy titled "Abuse, Neglect and Misappropriation", dated 04/2013, revealed all allegations of abuse were to be reported immediately to the Charge Nurse, who was responsible for contacting the DON and/or the Administrator. Continued review revealed if the DON and the Administrator were not in the facility, they were to be contacted by phone. Further review revealed all allegations of abuse were to be investigated. Review of the section "Resident to Resident" revealed the facility's response would include the following: complete a physical assessment to determine any potential injuries; closely supervise the residents, notify the Physician and families of the residents; and update the Care Plans.

Per review of the facility's, "Initial Report" form, dated 12/15/14, and an additional "Initial Report" form received by the State Survey Agency on 12/16/14, revealed Resident #1 had touched Resident #2 on 12/13/14, with no documentation as to where he/she touched the resident. Continued review revealed Resident #1 also touched Resident #2 on the breast on 12/15/14.

Interview with State Registered Nursing Assistant (SRNA) #1, on 12/13/14 at 3:30 PM, revealed Housekeeper #1 and Housekeeper #2 witnessed Resident #1 place his/her hand between Resident #2's legs in the thigh area. SRNA #1 told RN #4, who was the Weekend Supervisor.

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F 226

Interview with RN #4, on 12/24/13 at 2:50 PM, revealed he was the Supervisor on 12/13/14. He stated SRNA #1 reported to him Housekeepers #1 and #2 witnessed Resident #1 touching Resident #2 between the legs. He stated he instructed RN #3 to take written statements from both housekeepers related to the incident. RN #4 further revealed all he did was place the written statements on the Unit Manager's desk. There was no documented evidence RN #4 reported the alleged abuse incident to the DON or Administrator, and no documented evidence an investigation was initiated per the facility's policy.

Interview on 12/24/14 at 3:00 PM by phone with RN #3 revealed Resident #1 had touched Resident #2 between the thighs on 12/13/14. She stated Housekeepers #1 and #2 witnessed the incident, and she took their written statements. She further revealed she handed the Housekeepers witness statements to RN #4, who she expected would contact the DON. She further stated she did not understand she was considered a Charge Nurse and was also responsible for ensuring the allegation was reported and an investigation initiated.

Review of the clinical record for Resident #2 revealed no documented evidence a physical assessment was completed, or the Physician or family were notified, as per the Abuse Policy.

Review of the clinical record and the Comprehensive Care Plan for Resident #1 revealed no documented evidence of increased supervision, or contact of the Physician or family.

Review of Resident #1's Nurse's Note, dated

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12/15/14 at 7:10 AM, revealed RN #1 documented a "late entry" note for 12/14/14 at 3:10 PM. which stated SRNA's "on duty who worked day shift the previous day (Saturday 12/13/14)" informed RN #1, Resident #1 had "behaviors" on "Saturday", 12/13/14. Further review of the "late entry" note revealed the SRNAs also reported "housekeepers who witnessed" Resident #1's behaviors on 12/13/14, had "filled out statements"; however, RN #1 was unable to locate them. Continued review revealed no documented evidence the DON or Administrator were notified on 12/14/14 when RN #1 was made aware of an abuse allegation per the facility's policy.

Review of the State Survey Agency Intake Form revealed the facility submitted their initial report of the allegation of abuse on 12/15/14. Continued review revealed the facility sent additional information on 12/16/14 which indicated there had been another incident on 12/13/14, when Resident #1 "touched" Resident #2. Continued review of the Intake Form, including the initial and final reports by the facility, revealed no documented evidence of any investigation of the incident on 12/13/14 prior to the allegation of abuse made on 12/15/14.

Interview with the DON, on 12/31/14 at 10:10 AM, revealed it was her expectations for staff to follow the facility's Abuse Policy and report immediately any allegation of abuse, or signs or symptoms of abuse to their Charge Nurse. She further revealed it was her expectation that the Charge Nurse or Unit Manager immediately report the allegation to the DON or Administrator and initiate an investigation.

A post-survey interview with the Administrator, on

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01/15/15 at 11:25 AM, revealed after the incident on 12/13/14 was reported to the Charge Nurse and she informed the Weekend Supervisor, one (1) of them should have notified her, the DON, Abuse Coordinator and Social Services, as directed by the facility's Abuse Policy. She stated if staff had followed the Abuse Policy, an investigation could have been initiated immediately, and a report to the State Survey Agency made in a timely manner. She further stated it was possible, had she been notified of the allegation on 12/13/14, the incident on 12/15/14 "might not have occurred".

The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/29/14, which alleged removal of the IJ effective 12/20/14. Review of the AOC revealed the facility implemented the following corrective actions:

1) The allegation of resident to resident inappropriate touching on 12/13/14, was reported to the State Survey Agency, the Physician and the Power of Attorney (POA) for both residents on 12/16/14. A thorough investigation was initiated on 12/15/14 and concluded on 12/19/14 by the Administrator, the DON and Social Services. A five (5) day report was sent to the State Survey Agency and Adult Protective Services on 12/19/14. The Comprehensive Care Plans for Residents #1 and #2 were updated with appropriate interventions to meet each resident's care needs on 12/15/14 by the DON, Nursing Supervisors, or MDS Coordinator. Resident #2 was assessed on 12/15/14 by the Charge Nurse with no concerns noted. One to one (1:1) education was provided to RN #4 and RN #3 by the Administrator and the Regional Nurse Consultant by 12/19/14. Resident #1 was placed

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on 1:1 observation when out of bed and every fifteen (15) minute checks while in bed and a consult for psychiatric services was initiated. Social Services was consulted for follow-up with Resident #2 for psychosocial support and to identify any concerns for Resident #2.

2) All residents were assessed for any signs and symptoms of abuse/neglect. Residents with a BIMS score >8 were interviewed by the Social Services Director, Chaplain, Registered Dietitian, Human Resources, Environmental Director, Unit Managers, Nursing Supervisors, Admissions personnel, Restorative Nurse, Physician's nurses or the Administrator for any abuse/neglect concerns on 12/15/14. Residents with a BIMS score <8 were physically assessed by the nursing supervisors for any signs and symptoms of abuse/neglect. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator or the Regional Nurse Consultant (RNC) on 12/16/14 for any indications of abuse/neglect. No concerns were identified.

3) All resident charts were reviewed for any status changes in the past thirty (30) days by the DON, Nursing Supervisors, Unit Manager, Staff Development Coordinator (SDC), MDS staff, Medical Records personnel, Marketing/Admissions personnel, Social Service Director (SSD) or the RNC by 12/17/14 to ensure Physician and POA notifications were made and care plans were updated appropriately to reflect current resident care needs. No issues were identified.

4) Re-education on implementation of the Abuse Policy was provided by the Regional Nurse

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PRINTED: 01/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/31/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD WINCHESTER, KY 40391</b>
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Consultant on 12/15/14 and 12/16/14 for the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, Recreational Staff Manager, Medical Records, Human Resources, and designated charge nurses. Educational topics included: performing a thorough investigation; immediate reporting; updating the care plans according to facility policy; review of the policy related to accidents and incidents; review of the 24 Hour Report Policy; and notification of Physicians and family. The training was face-to-face to facilitate discussion. Examples of reportable incidents were discussed and a written post-test was administered. Those educated could not return to work until 100% score on the post-test was achieved.

5) After re-education by the RNC, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Services Manager, Medical Records personnel, and designated Charge Nurses were assigned to re-educate all staff. This education was initiated on 12/15/14 and completed on 12/19/14. Any staff who were on leave or had not completed the education by 12/19/14 was sent a certified letter informing them they could not return to work until they received the training. Each staff member was required to score 100% on the written post-test prior to returning to work. In addition, all newly-hired staff will be required to complete abuse training and score 100% on the post-test before beginning their job duties.

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6) Beginning 12/15/14, post-tests will be administered to ten (10) different staff daily, to include all shifts. Two (2) different tests will be utilized on alternating days to ensure ongoing retention and understanding of the provided abuse education. The tests will be administered by the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Environmental Services Director or Human Resources staff.

7) Human Resources personnel will audit all new employees hired since 10/22/14 for any abuse concerns. A total of twenty (20) new employees were reviewed. Audit results were reviewed by the RNC, Clinical Compliance Nurse or the Vice President of Operations on 12/17/14. No concerns were identified.

8) All grievances dated 11/15/14 to 12/15/14, and all new grievances beginning on 12/16/15 were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors or Regional Nurse Consultant to ensure all reportable allegations had been identified. A total of forty-one (41) grievances were reviewed.

9) All incident reports from 11/15/14 to 12/15/14 were reviewed by the DON, Assistant DON, SDC or RNC on 12/16/14 to identify any concerns of suspected neglect. A total of fifty-nine (59) reports were reviewed and no concerns were identified.

10) Beginning 12/15/14, a nurse from the regional team or corporate office will be onsite daily until

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the IJ is lifted. The nurses will assist with investigations, observations of staff treatment of residents, perform chart audits and provide oversight and consultation.

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11) The Administrator, DON, Nursing Supervisors and Department Heads will be onsite daily and make walking rounds of the facility. Five (5) residents with a BIMS score >8 will be interviewed and five (5) residents with a BIMS score <8 will be physically assessed for abuse concerns. In addition, staff assigned to the residents will be questioned regarding any behavioral changes exhibited by the residents. This will continued until the IJ is lifted. Then, three (3) residents with a BIMS score >8 and three (3) resident with a BIMS score <8 will be interviewed or assessed daily for four (4) weeks. All results will be reported at the weekly Quality Assurance (QA) meeting. At the end of the four (4) weeks, the QA committee will determine at what frequency the interviews, assessments and staff questionnaires need to continue. Any concerns identified will be addressed immediately, reported to the Administrator and an investigation initiated.

12) Beginning 12/16/14 and continuing until the IJ is lifted, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, or Human Resources will be on site daily to complete the Resident Status Monitoring Form. Completion of the form requires staff interviews, review of the 24 hour sheet, observations for documented behaviors, walking rounds with visualization of all residents,

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identification of any reportable incidents and reporting to the Charge Nurse and Administrator for any identified incidents. Also, the DON will daily review Physician orders to ensure appropriate notifications are made and care plans are updated, review the 24 hour sheets for any resident status changes, review ten (10) resident charts for any status changes without appropriate notifications and care plan updates, and initiate reporting and investigation of any accidents/incidents that are reported. All results will be reported at the weekly QA meeting. After removal of the IJ, the committee will determine at what frequency the Resident Status Monitoring form needs to be completed.

13) Beginning 12/15/14, the Administrator, DON, and Social Services or a member of the regional staff will review all resident interviews, assessments and staff questionnaires daily for any concerns, and initiate an investigation as indicated.

14) The Administrator, DON, and Social Services Director will review and discuss all abuse investigations daily, starting on 12/15/14, to ensure that the resident is protected, the perpetrator is removed from the resident care area, reports to the State Survey Agency are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log, and along with regional staff will review the log daily to ensure the above.

15) In the event of any new report of alleged abuse, neglect or misappropriation of property, the regional office will be notified within twenty-four (24) hours and again at the conclusion of the investigation to ensure a

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thorough investigation is completed and reporting timelines are met.

16) During Care Plan conferences with residents and families, abuse/neglect concerns will be discussed. In addition, education related to abuse, including reporting, will be provided with supporting documentation.

17) Beginning 12/15/14, administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of the regional staff daily until removal of the IJ, then weekly for four (4) weeks, then monthly.

18) Beginning 12/15/14, a QA meeting will be held weekly until the IJ is removed, then for four (4) more weeks, then monthly. During these meetings, the QA committee will review and evaluate the stated plan, make recommendations for plan revisions or re-education needs as identified, and determine at what frequency ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all facility staff.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1) Review of the State Agency Intake form revealed the initial facility report was received on 12/15/14 with additional information provided on 12/16/14. Continued review revealed the facility submitted a final report of their investigation on 12/19/14.

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Review of two (2) Incident Reports, one for Resident #1 and one for Resident #2, revealed the Physician and the POA for each resident were notified by the facility on 12/15/14.

Review of the Comprehensive Care Plan for Resident #1 revealed it was updated on 12/15/14 to include the following interventions: 1:1 observation of the resident when out of bed, with every fifteen (15) minute checks while in bed; consult to Psychiatric Services; and a medication review.

Review of the Comprehensive Care Plan for Resident #2 revealed revised interventions included: report changes in mood status to the Physician; support the resident's strengths and coping skills; and encourage expression of feelings.

Review of the Nurses Note dated 12/15/14 at 9:00 AM, revealed Resident #2 was assessed by the Charge Nurse with no signs of physical contact, bruising, redness or swelling identified.

Interview with the DON, on 12/24/14 at 4:15 PM, revealed RN #4 and RN #3 received 1:1 education on 12/15/14 related to their responsibilities when abuse was alleged. Review of education records revealed both nurses did receive the training and had completed post-tests with a 100% passing score.

Review of the Resident Monitoring Tool for the dates of 12/15/14 through 12/30/14 revealed Resident #1 was on 1:1 observation when out of the bed, and every fifteen (15) minute observations were made when the resident was

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in bed.

Further review of the Comprehensive Care Plan for Resident #1 revealed a consult was placed with the facility's contracted Psychiatric Services.

Review of Social Services notes, dated 12/15/14 through 12/19/14, revealed Residents #1 and #2 were followed daily. Discussion with Resident #1 included education related to inappropriate behaviors and ongoing support for the resident and the spouse. Resident #2 was assessed daily for mood changes. The Social Worker documented no psychosocial concerns were identified for either resident.

2) Review of the facility's AOC binder, which contained documents related to the corrective actions, revealed all residents were assessed for signs and symptoms of abuse/neglect on 12/15/14. Residents with a BIMS score >8 were interviewed related to any abuse/neglect concerns by the Social Services Director, Chaplain, Registered Dietitian, Unit Managers and Nursing Supervisors. Residents with a BIMS score <8 were physically assessed for any signs or symptoms of abuse by the Nursing Supervisors. A review of the audits, assessments, and interviews utilized revealed not identified concerns.

Interview with he Administrator on 12/31/14 at 10:30 AM revealed she reviewed all of the resident interviews and assessments on 12/16/14 with no concerns identified.

3) A review of chart audit records revealed all resident records were reviewed for falls, behaviors, accidents, abuse, Physician orders, 24

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hour reports, and notifications of the Physician, POA or family for any resident status change by 12/17/14. No concerns were identified.

4) Review of training records revealed the Administrator, DON, Nursing Supervisors, MDS Coordinator, Staff Development Coordinator, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Human Resources staff, and designated Charge Nurses were re-educated beginning on 12/15/14 and completed on 12/16/14 by the Regional Nurse Consultant. Topics covered included the Abuse Policy, investigations, care planning, notification of the Physician and family, and utilization of the 24 hour report to inform of a change in a resident's condition. Further review of documentation revealed all completed the post test with a 100% score.

Interviews with thirteen (13) administrative staff, including the Dietary Manager on 12/30/14 at 12:10 PM, the Registered Dietitian on 12/30/14 at 12:00 PM, the Director of Plan Operations on 12/30/14 at 3:00 PM, the SSD on 12/30/14 at 3:15 PM, Social Worker #2 on 12/30/14 at 3:30 PM, Charge Nurse #3 on 12/31/14 at 8:30 AM, Charge Nurse #2 on 12/31/14 at 9:15 AM, Unit Manager #1 on 12/31/14 at 9:15 AM, the DON on 12/31/14 at 10:30 AM, the Administrator on 12/31/14 at 10:45 AM, the SDC on 12/31/14 at 12:40 PM, the Chaplain on 12/31/14 at 1:00 PM and the Rehabilitation Manager on 12/31/14 at 1:00 PM revealed all were re-educated on performing a thorough investigation, reporting, updating care plans, the facility policy on incidents and accidents, the 24 hour report policy

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5) Further review of training records revealed all facility staff was re-educated on the facility's Abuse Policy, including identification and reporting, between 12/15/14 and 12/19/14. The training was provided by the DON, Administrator and the SDC.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed Practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational Therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed all received re-education by the DON, SDC, Administrator and Charge Nurses on identifying, reporting and investigating abuse. In addition, all interviewees stated they were required to complete the post-test with 100% accuracy prior to returning to work.

Review of the Certified letter revealed it was sent on 12/19/14 to all PRN (as needed) staff and all staff on vacation or medical leave. The letter informed the recipient to contact the DON or the

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SDC to complete mandatory in-services prior to their next shift.

6) Review of post-tests dated 12/15/14 -12/30/14 revealed ten (10) facility staff were receiving rotating tests daily. All completed tests were scored at 100%.

Interview with the DON, on 12/31/14 at 10:30 AM, revealed she coordinated with the Administrator, SDC and nursing Unit Managers for continuing staff education related to the abuse policy.

Interview with the Registered Dietitian, on 12/30/14 at 12:00 PM, revealed the department managers were responsible for administering abuse quizzes to assigned staff.

Interview with the Dietary Manager, on 12/30/14 at 12:10 PM, revealed she had an assigned day for assessing staff knowledge about abuse.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS

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Coordinator on 12/31/14 at 10:10 AM revealed they had received two (2) to three (3) quizzes per week to assess their retention and understanding of the information provided during the initial in-service.

7) A review of the Human Resources audit forms revealed twenty (20) newly hired staff since 10/22/14 were reviewed for any abuse concerns. The audits included a re-check of the Nurse Aide Abuse Registry to ensure no staff appeared on the Registry. Audit results were signed and dated as reviewed by the RNC on 12/17/14. No concerns were identified.

8) Review of the AOC binder revealed forty-one (41) grievances, dated 11/15/14 to 12/15/14, were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors, Regional Nurse Consultant on 12/16/14 with no concerns. Interview with the Administrator on 12/31/14 at 10:50 AM confirmed she had reviewed the grievances and that the grievances were continually reviewed daily from 12/16/14 to 12/30/14 to identify any reportable allegations which were not identified on the initial review.

9) Review of AOC binder revealed fifty-nine (59) incident reports, dated 11/15/14 to 12/15/14, were reviewed by the DON, Assistant Director of Nursing, Staff Development Coordinator and Regional Nurse consultant with no concerns identified.

10) Review of the daily sign off sheets, dated 12/15/14 -12/31/14 revealed the Regional Nurse Consultant was present daily at the facility.

11) Record review of walking rounds

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documentation, dated 12/15/14 to 12/30/14, revealed they were completed daily by the Administrator, DON, Nursing Supervisors, and Department Heads. The rounds included a physical assessment by the nurse for five (5) residents with a BIMS score <8, and interviews with five (5) residents with a BIMS score >8, concerning how the residents were treated by facility staff. In addition, nurses and SRNA's were interviewed regarding any changes in resident behaviors. Review of the QA meeting minutes revealed all results of resident and staff interviews, and skin assessments, were discussed during the weekly QA meetings.

12) Review of the Resident Status Monitoring Forms revealed they were completed daily by the Administrator, DON and Department Heads during walking rounds. The form included staff interviews, review of the 24 Hour Report sheet, observations of residents for documented behaviors, and identification of reportable incidents with evidence of a report to administration. Continued review revealed the DON conducted a follow-up daily to ensure Physician orders and ten (10) resident records were reviewed daily to ensure appropriate notifications and care plan revisions were made. The audits were reviewed, signed and dated daily by the Administrator.

13) Review of the AOC binder revealed it contained documented evidence the Administrator, DON, Social Services and RNC reviewed all resident interviews, assessments, and staff questionnaires daily between 12/15/14 and 12/31/14, with no identified concerns.

14) Review of Abuse Log forms, dated

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12/15/14-12/31/14, revealed the Administrator, DON and Social Service Director reviewed abuse allegations daily to track and trend for any additional needed interventions by the QA committee. All allegations were reviewed to ensure protection of residents by removal of the perpetrator, timeliness of reporting to the State Survey Agency, and initiation and completion of thorough investigations. Interview with the Administrator on 12/31/14 at 11:10 AM confirmed she would reviewed the abuse investigations and there were no new abuse allegations made during this period.

15) Review of the Abuse Log and review of documented daily walking rounds of the Administrator, DON and Department Heads, from 12/15/14 to 12/30/14, revealed no new abuse allegations or incidents suspicious for abuse were identified.

16) Review of the AOC binder and interview with the DON, on 12/31/14 at 1:00 PM, revealed no care plan conferences had taken place between 12/16/14 and 12/31/14. The DON stated the facility's plan for care plan conferences included discussion with the resident and/or family regarding any concerns they had about abuse. In addition, the DON stated during the meetings, education would be provided related to abuse, e.g. what abuse is and how to report abuse.

17) Review of the daily tracking form dated 12/16/14-12/30/14 revealed administrative oversight was provided by the RNC, onsite daily throughout the period.

18) Review of the QA minutes for the weekly meetings dated 12/15/14, 12/19/14 and 12/24/14

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revealed the Plan of Action for the cited deficiencies was discussed each time. Any changes to the QA Plan of Action were to be in bold print. No changes were made during these weekly meetings. Interview with the Administrator, on 12/31/14 at 10:20 AM, revealed if any changes were determined to be necessary, they would be reviewed by the entire QA team and communicated to facility staff. Continued interview with the Administrator revealed the QA weekly committee meetings consisted of all Department Heads, Unit Managers, Chaplain, Medical Director, Social Worker, Dietitian, Administrator and DON.

F 226

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

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

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F 280

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's "Initial Report" form and policy, it was determined the facility failed to have an effective system to ensure residents' Comprehensive Care Plans were reviewed and revised with interventions to provide appropriate supervision of residents and protect residents from abuse for two (2) of five (5) sampled residents (Resident #1 and Resident #2). (Refer to F223)

Interview and record review revealed Resident #1 had a history of exhibiting sexual behaviors towards residents and staff, including touching female breasts and buttocks. On 12/13/14 at 11:15 AM Housekeeper #1 and Housekeeper #2 witnessed Resident #1 touching Resident #2 on his/her thigh between the legs. The housekeepers informed State Registered Nurse Aide (SRNA) #1, who separated the residents and informed Registered Nurse (RN) #4/Weekend Supervisor of the observed incident. RN #4 instructed RN #3/Charge Nurse to have Housekeeper #1 and Housekeeper #2 provide written witness statements. Although Resident #1 and Resident #2 were separated, no physical assessment was completed for Resident #2; there was no documented evidence the facility implemented increased supervision of Resident #1; and, information concerning the incident was not passed on to subsequent shifts, verbally or in writing to protect the residents.

On 12/14/14 RN #1 heard Resident #2 talking about being touched. As RN #1 had not received any report of the incident on 12/13/14, she

Past noncompliance: no plan of correction required.

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assumed Resident #2 was speaking about something that happened in the past. RN #1 failed to report the concerns voiced by Resident #2. On 12/15/14, Resident #1 touched Resident #2 again. Resident #2 yelled out, pointed a finger at Resident #1, and stated Resident #1 had touched his/her breast and was "naughty" for doing so.

Although nurses were aware of the alleged abuse on 12/13/14, they failed to ensure Resident #1's Comprehensive Care Plan was updated and revised with interventions to prevent Resident #1 from having access to Resident #2 and to update and revise Resident #2's Comprehensive Care Plan to ensure protection of the resident from further abuse.

The facility's failure to have an effective system to ensure residents' care plans were revised to increase supervision/monitoring to protect residents from further abuse, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/24/14 and was determined to exist on 12/13/14. The facility was notified of the Immediate Jeopardy on 12/24/14.

An acceptable credible Allegation of Compliance (AOC) was received on 12/29/14. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected 12/20/14 prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

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The findings include:

Review of the facility's policy titled, "Care

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Plans-Comprehensive", undated, revealed a Comprehensive Care Plan was developed for each resident which identified the highest level of functioning each resident might be expected to attain. Continued review of the Policy revealed Comprehensive Care Plans were revised as necessary when a resident's condition changed.

Per review of the facility's, "Initial Report" form, dated 12/15/14, and an additional "Initial Report" form received by the State Survey Agency on 12/16/14, revealed Resident #1 had touched Resident #2 on 12/13/14, with no documentation as to where he/she touched the resident. Continued review revealed Resident #1 also touched Resident #2 on the breast on 12/15/14.

1. Review of Resident #1's record revealed the facility admitted him/her on 05/09/14, with diagnosis which included Dementia, Behavioral Disturbance and Psychosis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/31/14, revealed the facility assessed Resident #1 to have a Brief Interview Mental Status (BIMS) score of seven (7) which was indicative of severe cognitive impairment.

Review of the Behavioral Assessment form dated 05/28/14 and updated 08/07/14, revealed Resident #1 had a history of socially inappropriate disruptive behavior which included inappropriate sexual behaviors toward other residents and staff of touching breasts and buttocks. Further review of the Behavioral Assessment form revealed Resident #1's inappropriate behaviors also included being verbally abusive, yelling out, sticking his/her middle finger up in an obscene gesture and asking a visitor for a "blow job".

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F 280	Continued From page 90 Review of Resident #1's Comprehensive Care Plan dated 05/19/14, revealed the facility had care planned the resident for being at risk of behavioral problems, such as, yelling out, resident to resident altercation, sexual behaviors. Continued review of the behavioral care plan revealed it was updated on 11/03/14 to include an intervention for "observation by staff", however, there was no documented evidence of how often the observation was to occur. Additionally, there was no documented evidence Resident #1's care plan was revised after the incident which occurred on 12/13/14, to ensure supervision of the resident to prevent him/her from having further access to Resident #2.  2. Review of Resident #2's medical record revealed the facility admitted him/her on 01/15/14, with diagnosis which included Functional Decline, Dementia and Hypertension. functional decline, dementia, hypertension. Review of the Annual MDS Assessment dated 11/17/14, revealed the facility assessed Resident #2 to have a BIMS score of three (3) which was indicative of severe cognitive impairment.  Review of Resident #2's Comprehensive Care Plan revealed a care plan for impaired cognitive skills related to disease process of Dementia. Continued review of the impaired cognitive skills care plan revealed it was revised on 10/16/14, for staff to "reassure" Resident #2 of his/her "safety" when the resident verbalized "a focus on the past". However, there was no documented evidence Resident #2's care plan was revised after the incident on 12/13/14, to ensure protection of the resident from further abuse.  Further review of Resident #1's and Resident #2's	F 280		

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Comprehensive Care Plans revealed no documented evidence the care plans were updated or revised until 12/15/14.

Interview with RN #4/Weekend Supervisor on 12/24/14 at 2:50 PM and the RN #3/Charge Nurse on 12/24/14 at 3:00 PM, revealed they were informed of the incident involving Resident #1 touching Resident #2 between the legs on 12/13/14. However, the residents' care plan had not been revised.

Interview, on 12/31/14 at 10:10 AM, with MDS Coordinator #1 revealed MDS nurses were responsible for updating and revising residents' Comprehensive Care Plans during the Quarterly, Annual and Significant Change MDS Assessment period. Per interview, the nurses caring for residents and the Unit Managers were responsible for "day to day" updates or revisions to residents' care plans.

Interview, on 12/31/14 at 10:30 AM, with the Director of Nursing (DON) revealed it was her expectation for residents' "primary care" nurse or the Charge Nurse to ensure residents' care plans were updated or revised as necessary.

A post-survey interview with the Administrator on 01/15/15 at 11:25 AM, revealed the nurses in charge of Resident #1's and Resident #2's care should have updated the residents' care plans on 12/13/14; however, did not do so. Per interview, if staff had followed the facility's policy on 12/13/14, however, an investigation would have been initiated and the residents' care plans could have been updated and revised with other interventions put in place.

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The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/29/14, which alleged removal of the IJ effective 12/20/14. Review of the AOC revealed the facility implemented the following corrective actions:

F 280

1) The allegation of resident to resident inappropriate touching on 12/13/14, was reported to the State Survey Agency, the Physician and the Power of Attorney (POA) for both residents on 12/16/14. A thorough investigation was initiated on 12/15/14 and concluded on 12/19/14 by the Administrator, the DON and Social Services. A five (5) day report was sent to the State Survey Agency and Adult Protective Services on 12/19/14. The Comprehensive Care Plans for Residents #1 and #2 were updated with appropriate interventions to meet each resident's care needs on 12/15/14 by the DON, Nursing Supervisors, or MDS Coordinator. Resident #2 was assessed on 12/15/14 by the Charge Nurse with no concerns noted. One to one (1:1) education was provided to RN #4 and RN #3 by the Administrator and the Regional Nurse Consultant by 12/19/14. Resident #1 was placed on 1:1 observation when out of bed and every fifteen (15) minute checks while in bed and a consult for psychiatric services was initiated. Social Services was consulted for follow-up with Resident #2 for psychosocial support and to identify any concerns for Resident #2.

2) All residents were assessed for any signs and symptoms of abuse/neglect. Residents with a BIMS score >8 were interviewed by the Social Services Director, Chaplain, Registered Dietitian, Human Resources, Environmental Director, Unit Managers, Nursing Supervisors, Admissions personnel, Restorative Nurse, Physician's nurses

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or the Administrator for any abuse/neglect concerns on 12/15/14. Residents with a BIMS score <8 were physically assessed by the nursing supervisors for any signs and symptoms of abuse/neglect. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator or the Regional Nurse Consultant (RNC) on 12/16/14 for any indications of abuse/neglect. No concerns were identified.

3) All resident charts were reviewed for any status changes in the past thirty (30) days by the DON, Nursing Supervisors, Unit Manager, Staff Development Coordinator (SDC), MDS staff, Medical Records personnel, Marketing/Admissions personnel, Social Service Director (SSD) or the RNC by 12/17/14 to ensure Physician and POA notifications were made and care plans were updated appropriately to reflect current resident care needs. No issues were identified.

4) Re-education on implementation of the Abuse Policy was provided by the Regional Nurse Consultant on 12/15/14 and 12/16/14 for the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, Recreational Staff Manager, Medical Records, Human Resources, and designated charge nurses. Educational topics included: performing a thorough investigation; immediate reporting; updating the care plans according to facility policy; review of the policy related to accidents and incidents; review of the 24 Hour Report Policy; and notification of Physicians and family. The training

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was face-to-face to facilitate discussion. Examples of reportable incidents were discussed and a written post-test was administered. Those educated could not return to work until 100% score on the post-test was achieved.

5) After re-education by the RNC, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Services Manager, Medical Records personnel, and designated Charge Nurses were assigned to re-educate all staff. This education was initiated on 12/15/14 and completed on 12/19/14. Any staff who were on leave or had not completed the education by 12/19/14 was sent a certified letter informing them they could not return to work until they received the training. Each staff member was required to score 100% on the written post-test prior to returning to work. In addition, all newly-hired staff will be required to complete abuse training and score 100% on the post-test before beginning their job duties.

6) Beginning 12/15/14, post-tests will be administered to ten (10) different staff daily, to include all shifts. Two (2) different tests will be utilized on alternating days to ensure ongoing retention and understanding of the provided abuse education. The tests will be administered by the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Environmental Services Director or Human Resources staff.

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F 280	<p>Continued From page 95</p> <p>7) Human Resources personnel will audit all new employees hired since 10/22/14 for any abuse concerns. A total of twenty (20) new employees were reviewed. Audit results were reviewed by the RNC, Clinical Compliance Nurse or the Vice President of Operations on 12/17/14. No concerns were identified.</p> <p>8) All grievances dated 11/15/14 to 12/15/14, and all new grievances beginning on 12/16/15 were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors or Regional Nurse Consultant to ensure all reportable allegations had been identified. A total of forty-one (41) grievances were reviewed.</p> <p>9) All incident reports from 11/15/14 to 12/15/14 were reviewed by the DON, Assistant DON, SDC or RNC on 12/16/14 to identify any concerns of suspected neglect. A total of fifty-nine (59) reports were reviewed and no concerns were identified.</p> <p>10) Beginning 12/15/14, a nurse from the regional team or corporate office will be onsite daily until the IJ is lifted. The nurses will assist with investigations, observations of staff treatment of residents, perform chart audits and provide oversight and consultation.</p> <p>11) The Administrator, DON, Nursing Supervisors and Department Heads will be onsite daily and make walking rounds of the facility. Five (5) residents with a BIMS score &gt;8 will be interviewed and five (5) residents with a BIMS score &lt;8 will be physically assessed for abuse concerns. In addition, staff assigned to the residents will be questioned regarding any behavioral changes exhibited by the residents.</p>	F 280		
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F 280 Continued From page 96  
This will continued until the IJ is lifted. Then, three (3) residents with a BIMS score >8 and three (3) resident with a BIMS score <8 will be interviewed or assessed daily for four (4) weeks. All results will be reported at the weekly Quality Assurance (QA) meeting. At the end of the four (4) weeks, the QA committee will determine at what frequency the interviews, assessments and staff questionnaires need to continue. Any concerns identified will be addressed immediately, reported to the Administrator and an investigation initiated.

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12) Beginning 12/16/14 and continuing until the IJ is lifted, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, or Human Resources will be on site daily to complete the Resident Status Monitoring Form. Completion of the form requires staff interviews, review of the 24 hour sheet, observations for documented behaviors, walking rounds with visualization of all residents, identification of any reportable incidents and reporting to the Charge Nurse and Administrator for any identified incidents. Also, the DON will daily review Physician orders to ensure appropriate notifications are made and care plans are updated, review the 24 hour sheets for any resident status changes, review ten (10) resident charts for any status changes without appropriate notifications and care plan updates, and initiate reporting and investigation of any accidents/incidents that are reported. All results will be reported at the weekly QA meeting. After removal of the IJ, the committee will determine at what frequency the Resident Status Monitoring

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Continued From page 97  
form needs to be completed.

13) Beginning 12/15/14, the Administrator, DON, and Social Services or a member of the regional staff will review all resident interviews, assessments and staff questionnaires daily for any concerns, and initiate an investigation as indicated.

14) The Administrator, DON, and Social Services Director will review and discuss all abuse investigations daily, starting on 12/15/14, to ensure that the resident is protected, the perpetrator is removed from the resident care area, reports to the State Survey Agency are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log, and along with regional staff will review the log daily to ensure the above.

15) In the event of any new report of alleged abuse, neglect or misappropriation of property, the regional office will be notified within twenty-four (24) hours and again at the conclusion of the investigation to ensure a thorough investigation is completed and reporting timelines are met.

16) During Care Plan conferences with residents and families, abuse/neglect concerns will be discussed. In addition, education related to abuse, including reporting, will be provided with supporting documentation.

17) Beginning 12/15/14, administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or a member of the regional staff daily until removal of the IJ, then

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F 280	Continued From page 98 weekly for four (4) weeks, then monthly.	F 280		
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18) Beginning 12/15/14, a QA meeting will be held weekly until the IJ is removed, then for four (4) more weeks, then monthly. During these meetings, the QA committee will review and evaluate the stated plan, make recommendations for plan revisions or re-education needs as identified, and determine at what frequency ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all facility staff.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1) Review of the State Agency Intake form revealed the initial facility report was received on 12/15/14 with additional information provided on 12/16/14. Continued review revealed the facility submitted a final report of their investigation on 12/19/14.

Review of two (2) Incident Reports, one for Resident #1 and one for Resident #2, revealed the Physician and the POA for each resident were notified by the facility on 12/15/14.

Review of the Comprehensive Care Plan for Resident #1 revealed it was updated on 12/15/14 to include the following interventions: 1:1 observation of the resident when out of bed, with every fifteen (15) minute checks while in bed; consult to Psychiatric Services; and a medication review.

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Review of the Comprehensive Care Plan for Resident #2 revealed revised interventions included: report changes in mood status to the Physician; support the resident's strengths and coping skills; and encourage expression of feelings.

Review of the Nurses Note dated 12/15/14 at 9:00 AM, revealed Resident #2 was assessed by the Charge Nurse with no signs of physical contact, bruising, redness or swelling identified.

Interview with the DON, on 12/24/14 at 4:15 PM, revealed RN #4 and RN #3 received 1:1 education on 12/15/14 related to their responsibilities when abuse was alleged. Review of education records revealed both nurses did receive the training and had completed post-tests with a 100% passing score.

Review of the Resident Monitoring Tool for the dates of 12/15/14 through 12/30/14 revealed Resident #1 was on 1:1 observation when out of the bed, and every fifteen (15) minute observations were made when the resident was in bed.

Further review of the Comprehensive Care Plan for Resident #1 revealed a consult was placed with the facility's contracted Psychiatric Services.

Review of Social Services notes, dated 12/15/14 through 12/19/14, revealed Residents #1 and #2 were followed daily. Discussion with Resident #1 included education related to inappropriate behaviors and ongoing support for the resident and the spouse. Resident #2 was assessed daily for mood changes. The Social Worker documented no psychosocial concerns were

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F 280 Continued From page 100 identified for either resident. F 280

2) Review of the facility's AOC binder, which contained documents related to the corrective actions, revealed all residents were assessed for signs and symptoms of abuse/neglect on 12/15/14. Residents with a BIMS score >8 were interviewed related to any abuse/neglect concerns by the Social Services Director, Chaplain, Registered Dietitian, Unit Managers and Nursing Supervisors. Residents with a BIMS score <8 were physically assessed for any signs or symptoms of abuse by the Nursing Supervisors. A review of the audits, assessments, and interviews utilized revealed not identified concerns.

Interview with he Administrator on 12/31/14 at 10:30 AM revealed she reviewed all of the resident interviews and assessments on 12/16/14 with no concerns identified.

3) A review of chart audit records revealed all resident records were reviewed for falls, behaviors, accidents, abuse, Physician orders, 24 hour reports, and notifications of the Physician, POA or family for any resident status change by 12/17/14. No concerns were identified.

4) Review of training records revealed the Administrator, DON, Nursing Supervisors, MDS Coordinator, Staff Development Coordinator, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Human Resources staff, and designated Charge Nurses were re-educated beginning on 12/15/14 and completed on 12/16/14 by the Regional

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Nurse Consultant. Topics covered included the Abuse Policy, investigations, care planning, notification of the Physician and family, and utilization of the 24 hour report to inform of a change in a resident's condition. Further review of documentation revealed all completed the post test with a 100% score.

Interviews with thirteen (13) administrative staff, including the Dietary Manager on 12/30/14 at 12:10 PM, the Registered Dietitian on 12/30/14 at 12:00 PM, the Director of Plan Operations on 12/30/14 at 3:00 PM, the SSD on 12/30/14 at 3:15 PM, Social Worker #2 on 12/30/14 at 3:30 PM, Charge Nurse #3 on 12/31/14 at 8:30 AM, Charge Nurse #2 on 12/31/14 at 9:15 AM, Unit Manager #1 on 12/31/14 at 9:15 AM, the DON on 12/31/14 at 10:30 AM, the Administrator on 12/31/14 at 10:45 AM, the SDC on 12/31/14 at 12:40 PM, the Chaplain on 12/31/14 at 1:00 PM and the Rehabilitation Manager on 12/31/14 at 1:00 PM revealed all were re-educated on performing a thorough investigation, reporting, updating care plans, the facility policy on incidents and accidents, the 24 hour report policy and notifications by the Regional Nurse Consultant and completed a post-test.

5) Further review of training records revealed all facility staff was re-educated on the facility's Abuse Policy, including identification and reporting, between 12/15/14 and 12/19/14. The training was provided by the DON, Administrator and the SDC.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed Practical Nurse

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(LPN) #2 on 12/30/14 at 12:15 PM, Occupational Therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed all received re-education by the DON, SDC, Administrator and Charge Nurses on identifying, reporting and investigating abuse. In addition, all interviewees stated they were required to complete the post-test with 100% accuracy prior to returning to work.

Review of the Certified letter revealed it was sent on 12/19/14 to all PRN (as needed) staff and all staff on vacation or medical leave. The letter informed the recipient to contact the DON or the SDC to complete mandatory in-services prior to their next shift.

6) Review of post-tests dated 12/15/14 -12/30/14 revealed ten (10) facility staff were receiving rotating tests daily. All completed tests were scored at 100%.

Interview with the DON, on 12/31/14 at 10:30 AM, revealed she coordinated with the Administrator, SDC and nursing Unit Managers for continuing staff education related to the abuse policy.

Interview with the Registered Dietitian, on

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12/30/14 at 12:00 PM, revealed the department managers were responsible for administering abuse quizzes to assigned staff.

Interview with the Dietary Manager, on 12/30/14 at 12:10 PM, revealed she had an assigned day for assessing staff knowledge about abuse.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed they had received two (2) to three (3) quizzes per week to assess their retention and understanding of the information provided during the initial in-service.

7) A review of the Human Resources audit forms revealed twenty (20) newly hired staff since 10/22/14 were reviewed for any abuse concerns. The audits included a re-check of the Nurse Aide Abuse Registry to ensure no staff appeared on the Registry. Audit results were signed and dated as reviewed by the RNC on 12/17/14. No concerns were identified.

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8) Review of the AOC binder revealed forty-one (41) grievances, dated 11/15/14 to 12/15/14, were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors, Regional Nurse Consultant on 12/16/14 with no concerns. Interview with the Administrator on 12/31/14 at 10:50 AM confirmed she had reviewed the grievances and that the grievances were continually reviewed daily from 12/16/14 to 12/30/14 to identify any reportable allegations which were not identified on the initial review.

9) Review of AOC binder revealed fifty-nine (59) incident reports, dated 11/15/14 to 12/15/14, were reviewed by the DON, Assistant Director of Nursing, Staff Development Coordinator and Regional Nurse consultant with no concerns identified.

10) Review of the daily sign off sheets, dated 12/15/14 -12/31/14 revealed the Regional Nurse Consultant was present daily at the facility.

11) Record review of walking rounds documentation, dated 12/15/14 to 12/30/14, revealed they were completed daily by the Administrator, DON, Nursing Supervisors, and Department Heads. The rounds included a physical assessment by the nurse for five (5) residents with a BIMS score <8, and interviews with five (5) residents with a BIMS score >8, concerning how the residents were treated by facility staff. In addition, nurses and SRNA's were interviewed regarding any changes in resident behaviors. Review of the QA meeting minutes revealed all results of resident and staff interviews, and skin assessments, were discussed during the weekly QA meetings.

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12) Review of the Resident Status Monitoring Forms revealed they were completed daily by the Administrator, DON and Department Heads during walking rounds. The form included staff interviews, review of the 24 Hour Report sheet, observations of residents for documented behaviors, and identification of reportable incidents with evidence of a report to administration. Continued review revealed the DON conducted a follow-up daily to ensure Physician orders and ten (10) resident records were reviewed daily to ensure appropriate notifications and care plan revisions were made. The audits were reviewed, signed and dated daily by the Administrator.

13) Review of the AOC binder revealed it contained documented evidence the Administrator, DON, Social Services and RNC reviewed all resident interviews, assessments, and staff questionnaires daily between 12/15/14 and 12/31/14, with no identified concerns.

14) Review of Abuse Log forms, dated 12/15/14-12/31/14, revealed the Administrator, DON and Social Service Director reviewed abuse allegations daily to track and trend for any additional needed interventions by the QA committee. All allegations were reviewed to ensure protection of residents by removal of the perpetrator, timeliness of reporting to the State Survey Agency, and initiation and completion of thorough investigations. Interview with the Administrator on 12/31/14 at 11:10 AM confirmed she would reviewed the abuse investigations and there were no new abuse allegations made during this period.

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15) Review of the Abuse Log and review of documented daily walking rounds of the Administrator, DON and Department Heads, from 12/15/14 to 12/30/14, revealed no new abuse allegations or incidents suspicious for abuse were identified.

16) Review of the AOC binder and interview with the DON, on 12/31/14 at 1:00 PM, revealed no care plan conferences had taken place between 12/16/14 and 12/31/14. The DON stated the facility's plan for care plan conferences included discussion with the resident and/or family regarding any concerns they had about abuse. In addition, the DON stated during the meetings, education would be provided related to abuse, e.g. what abuse is and how to report abuse.

17) Review of the daily tracking form dated 12/16/14-12/30/14 revealed administrative oversight was provided by the RNC, onsite daily throughout the period.

18) Review of the QA minutes for the weekly meetings dated 12/15/14, 12/19/14 and 12/24/14 revealed the Plan of Action for the cited deficiencies was discussed each time. Any changes to the QA Plan of Action were to be in bold print. No changes were made during these weekly meetings. Interview with the Administrator, on 12/31/14 at 10:20 AM, revealed if any changes were determined to be necessary, they would be reviewed by the entire QA team and communicated to facility staff. Continued interview with the Administrator revealed the QA weekly committee meetings consisted of all Department Heads, Unit Managers, Chaplain, Medical Director, Social Worker, Dietitian, Administrator and DON.

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exist on 12/13/14. The facility was notified of the Immediate Jeopardy on 12/24/14.

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An acceptable credible Allegation of Compliance (AOC) was received on 12/29/14. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected on 12/20/14 prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

The findings include:

Review of the facility's policy titled, "Abuse, Neglect and Misappropriation", dated April 2013, revealed all allegations of abuse were to be reported immediately to the Charge Nurse and/or Administrator, and the Physician and residents' families were to be notified.

Record review revealed the facility admitted Resident #1 on 05/09/14, with diagnosis which included Psychosis, Dementia and Behavioral Disturbance. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/31/14, revealed the facility assessed Resident #1 to have a Brief Interview Mental Status (BIMS) score of seven (7), indicating the resident was severely cognitively impaired. Review of the Behavioral Assessment form dated 05/28/14 and updated 08/07/14, revealed Resident #1 had a history of sexual behaviors toward other residents and staff by touching breast and buttocks, and other socially inappropriate disruptive behavioral symptoms, such as, asking a visitor for a "blow job". Review of the Behavioral Assessment form dated 12/15/14, revealed Resident #1 had touched a female resident inappropriately. However, further record review revealed no

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documented evidence Resident #1's Physician and family/responsible party were notified of incident on 12/13/14.

Record review revealed the facility admitted Resident #2 on 01/15/14, with diagnosis which included Dementia and Functional Decline. Review of the 11/17/14 Annual MDS Assessment revealed the facility assessed Resident #2 to have a BIMS score of three (3) indicating the resident was severely cognitively impaired.

Review of the facility's "Initial Report" forms, dated 12/15/14 and 12/16/14, revealed the forms were regarding resident to resident incidents. Per the "Initial Report" forms Resident #1 had touched Resident #2 on 12/13/14, but the "Initial Report" forms did not indicate where he/she touched Resident #2 on that date. Further review of the "Initial Report" forms revealed Resident #1 again touched Resident #2 on 12/15/14, on the breast.

Interview, on 12/24/14 at 2:50 PM, with RN #4/Weekend Supervisor revealed he had worked on 12/13/14, and was informed of what Housekeeper #1 and Housekeeper #2 witnessed regarding Resident # touching Resident #2 between the legs. Further interview revealed he should have contacted the DON, Administrator, Physician and residents' families himself; however, had not done this.

Interview, on 12/24/14 at 3:00 PM, with RN #3 revealed on 12/13/14 Housekeeper #1 and Housekeeper #2 reported Resident #1 touched Resident #2 between the thighs. RN #3 revealed even though she was the Charge Nurse, she thought since RN #4/Weekend Supervisor, was

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aware of the incident and would perform the necessary notifications. Per interview, she had not realized as the Charge Nurse she should have notified the DON, Physician and residents' families of the incident.

Continued review of Resident #1's and Resident #2's medical records revealed no documented evidence of the Physician and family/responsible party having been notified of the alleged abuse on 12/13/14.

Interview on 12/23/14 at 2:57 PM RN #1 revealed she worked on 12/14/14 and 12/15/14 7:00 AM to 7:00 PM shift. Per interview, on 12/14/14 she overheard a conversation Resident #2 was having with visitors in which she stated a male resident had touched him/her. RN #1 stated SRNA #1 told her two (2) housekeepers had seen Resident #1 touch Resident #2 on the thigh area, between the legs on 12/13/14; however, she had not received any information in shift report on 12/14/14, related to an alleged sexual abuse incident regarding Resident #1 and Resident #2. RN #1 reported she asked Resident #2 when Resident #1 touched him/her and the resident revealed it was recently.

However, further record review revealed no documented evidence the Physician or family/responsible were notified of the information RN #1 obtained on 12/14/14, regarding alleged sexual abuse of Resident #2 by Resident #1.

Interview with Resident #2's Power of Attorney (POA) for Resident #2, on 12/24/14 at 12:52 PM, revealed she was not contacted by the facility related to an incident of alleged abuse until 12/15/14.

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Interview, on 12/31/14 at 10:10 AM, with the DON revealed her expectations were for staff to follow the facility's policies. The DON revealed the Charge Nurse, or each residents' primary care nurse should notify the Physician and residents' families/responsible party, and document all of their actions in the residents chart.

Post-survey interview, on 01/15/15 at 11:25 AM, with the Administrator revealed Resident #1's and Resident #2's Physician and family/responsible party should have been notified of the incident on 12/13/14 after staff were aware. Per interview, this was not done until after the second incident on 12/14/14. According to the Administrator, if staff on 12/13/14 had followed the policy an investigation could have been initiated to include notification of the Physician and family/responsible party.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/29/14, which alleged removal of the IJ effective 12/20/14. Review of the AOC revealed the facility implemented the following corrective actions:

- 1) The allegation of resident to resident inappropriate touching on 12/13/14, was reported to the State Survey Agency, the Physician and the Power of Attorney (POA) for both residents on 12/16/14. A thorough investigation was initiated on 12/15/14 and concluded on 12/19/14 by the Administrator, the DON and Social Services. A five (5) day report was sent to the State Survey Agency and Adult Protective Services on 12/19/14. The Comprehensive Care Plans for Residents #1 and #2 were updated with appropriate interventions to meet each resident's

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care needs on 12/15/14 by the DON, Nursing Supervisors, or MDS Coordinator. Resident #2 was assessed on 12/15/14 by the Charge Nurse with no concerns noted. One to one (1:1) education was provided to RN #4 and RN #3 by the Administrator and the Regional Nurse Consultant by 12/19/14. Resident #1 was placed on 1:1 observation when out of bed and every fifteen (15) minute checks while in bed and a consult for psychiatric services was initiated. Social Services was consulted for follow-up with Resident #2 for psychosocial support and to identify any concerns for Resident #2.

2) All residents were assessed for any signs and symptoms of abuse/neglect. Residents with a BIMS score >8 were interviewed by the Social Services Director, Chaplain, Registered Dietitian, Human Resources, Environmental Director, Unit Managers, Nursing Supervisors, Admissions personnel, Restorative Nurse, Physician's nurses or the Administrator for any abuse/neglect concerns on 12/15/14. Residents with a BIMS score <8 were physically assessed by the nursing supervisors for any signs and symptoms of abuse/neglect. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator or the Regional Nurse Consultant (RNC) on 12/16/14 for any indications of abuse/neglect. No concerns were identified.

3) All resident charts were reviewed for any status changes in the past thirty (30) days by the DON, Nursing Supervisors, Unit Manager, Staff Development Coordinator (SDC), MDS staff, Medical Records personnel, Marketing/Admissions personnel, Social Service Director (SSD) or the RNC by 12/17/14 to ensure

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F 157	<p>Continued From page 9</p> <p>Physician and POA notifications were made and care plans were updated appropriately to reflect current resident care needs. No issues were identified.</p> <p>4) Re-education on implementation of the Abuse Policy was provided by the Regional Nurse Consultant on 12/15/14 and 12/16/14 for the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, Recreational Staff Manager, Medical Records, Human Resources, and designated charge nurses. Educational topics included: performing a thorough investigation; immediate reporting; updating the care plans according to facility policy; review of the policy related to accidents and incidents; review of the 24 Hour Report Policy; and notification of Physicians and family. The training was face-to-face to facilitate discussion. Examples of reportable incidents were discussed and a written post-test was administered. Those educated could not return to work until 100% score on the post-test was achieved.</p> <p>5) After re-education by the RNC, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Services Manager, Medical Records personnel, and designated Charge Nurses were assigned to re-educate all staff. This education was initiated on 12/15/14 and completed on 12/19/14. Any staff who were on leave or had not completed the education by 12/19/14 was sent a certified letter informing them they could not</p>	F 157		
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return to work until they received the training. Each staff member was required to score 100% on the written post-test prior to returning to work. In addition, all newly-hired staff will be required to complete abuse training and score 100% on the post-test before beginning their job duties.

6) Beginning 12/15/14, post-tests will be administered to ten (10) different staff daily, to include all shifts. Two (2) different tests will be utilized on alternating days to ensure ongoing retention and understanding of the provided abuse education. The tests will be administered by the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Environmental Services Director or Human Resources staff.

7) Human Resources personnel will audit all new employees hired since 10/22/14 for any abuse concerns. A total of twenty (20) new employees were reviewed. Audit results were reviewed by the RNC, Clinical Compliance Nurse or the Vice President of Operations on 12/17/14. No concerns were identified.

8) All grievances dated 11/15/14 to 12/15/14, and all new grievances beginning on 12/16/15 were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors or Regional Nurse Consultant to ensure all reportable allegations had been identified. A total of forty-one (41) grievances were reviewed.

9) All incident reports from 11/15/14 to 12/15/14 were reviewed by the DON, Assistant DON, SDC

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or RNC on 12/16/14 to identify any concerns of suspected neglect. A total of fifty-nine (59) reports were reviewed and no concerns were identified.

10) Beginning 12/15/14, a nurse from the regional team or corporate office will be onsite daily until the IJ is lifted. The nurses will assist with investigations, observations of staff treatment of residents, perform chart audits and provide oversight and consultation.

11) The Administrator, DON, Nursing Supervisors and Department Heads will be onsite daily and make walking rounds of the facility. Five (5) residents with a BIMS score >8 will be interviewed and five (5) residents with a BIMS score <8 will be physically assessed for abuse concerns. In addition, staff assigned to the residents will be questioned regarding any behavioral changes exhibited by the residents. This will continued until the IJ is lifted. Then, three (3) residents with a BIMS score >8 and three (3) resident with a BIMS score <8 will be interviewed or assessed daily for four (4) weeks. All results will be reported at the weekly Quality Assurance (QA) meeting. At the end of the four (4) weeks, the QA committee will determine at what frequency the interviews, assessments and staff questionnaires need to continue. Any concerns identified will be addressed immediately, reported to the Administrator and an investigation initiated.

12) Beginning 12/16/14 and continuing until the IJ is lifted, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions

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personnel, Recreational Staff Manager, Medical Records personnel, or Human Resources will be on site daily to complete the Resident Status Monitoring Form. Completion of the form requires staff interviews, review of the 24 hour sheet, observations for documented behaviors, walking rounds with visualization of all residents, identification of any reportable incidents and reporting to the Charge Nurse and Administrator for any identified incidents. Also, the DON will daily review Physician orders to ensure appropriate notifications are made and care plans are updated, review the 24 hour sheets for any resident status changes, review ten (10) resident charts for any status changes without appropriate notifications and care plan updates, and initiate reporting and investigation of any accidents/incidents that are reported. All results will be reported at the weekly QA meeting. After removal of the IJ, the committee will determine at what frequency the Resident Status Monitoring form needs to be completed.

13) Beginning 12/15/14, the Administrator, DON, and Social Services or a member of the regional staff will review all resident interviews, assessments and staff questionnaires daily for any concerns, and initiate an investigation as indicated.

14) The Administrator, DON, and Social Services Director will review and discuss all abuse investigations daily, starting on 12/15/14, to ensure that the resident is protected, the perpetrator is removed from the resident care area, reports to the State Survey Agency are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log, and along with regional staff will

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F 157	<p>Continued From page 13 review the log daily to ensure the above.</p> <p>15) In the event of any new report of alleged abuse, neglect or misappropriation of property, the regional office will be notified within twenty-four (24) hours and again at the conclusion of the investigation to ensure a thorough investigation is completed and reporting timelines are met.</p> <p>16) During Care Plan conferences with residents and families, abuse/neglect concerns will be discussed. In addition, education related to abuse, including reporting, will be provided with supporting documentation.</p> <p>17) Beginning 12/15/14, administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of the regional staff daily until removal of the IJ, then weekly for four (4) weeks, then monthly.</p> <p>18) Beginning 12/15/14, a QA meeting will be held weekly until the IJ is removed, then for four (4) more weeks, then monthly. During these meetings, the QA committee will review and evaluate the stated plan, make recommendations for plan revisions or re-education needs as identified, and determine at what frequency ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all facility staff.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p>	F 157		
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F 157 : Continued From page 14

F 157 :

1) Review of the State Agency Intake form revealed the initial facility report was received on 12/15/14 with additional information provided on 12/16/14. Continued review revealed the facility submitted a final report of their investigation on 12/19/14.

Review of two (2) Incident Reports, one for Resident #1 and one for Resident #2, revealed the Physician and the POA for each resident were notified by the facility on 12/15/14.

Review of the Comprehensive Care Plan for Resident #1 revealed it was updated on 12/15/14 to include the following interventions: 1:1 observation of the resident when out of bed, with every fifteen (15) minute checks while in bed; consult to Psychiatric Services; and a medication review.

Review of the Comprehensive Care Plan for Resident #2 revealed revised interventions included: report changes in mood status to the Physician; support the resident's strengths and coping skills; and encourage expression of feelings.

Review of the Nurses Note dated 12/15/14 at 9:00 AM, revealed Resident #2 was assessed by the Charge Nurse with no signs of physical contact, bruising, redness or swelling identified.

Interview with the DON, on 12/24/14 at 4:15 PM, revealed RN #4 and RN #3 received 1:1 education on 12/15/14 related to their responsibilities when abuse was alleged. Review of education records revealed both nurses did receive the training and had completed post-tests

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Continued From page 15 with a 100% passing score.

Review of the Resident Monitoring Tool for the dates of 12/15/14 through 12/30/14 revealed Resident #1 was on 1:1 observation when out of the bed, and every fifteen (15) minute observations were made when the resident was in bed.

Further review of the Comprehensive Care Plan for Resident #1 revealed a consult was placed with the facility's contracted Psychiatric Services.

Review of Social Services notes, dated 12/15/14 through 12/19/14, revealed Residents #1 and #2 were followed daily. Discussion with Resident #1 included education related to inappropriate behaviors and ongoing support for the resident and the spouse. Resident #2 was assessed daily for mood changes. The Social Worker documented no psychosocial concerns were identified for either resident.

2) Review of the facility's AOC binder, which contained documents related to the corrective actions, revealed all residents were assessed for signs and symptoms of abuse/neglect on 12/15/14. Residents with a BIMS score >8 were interviewed related to any abuse/neglect concerns by the Social Services Director, Chaplain, Registered Dietitian, Unit Managers and Nursing Supervisors. Residents with a BIMS score <8 were physically assessed for any signs or symptoms of abuse by the Nursing Supervisors. A review of the audits, assessments, and interviews utilized revealed not identified concerns.

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Interview with he Administrator on 12/31/14 at

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10:30 AM revealed she reviewed all of the resident interviews and assessments on 12/16/14 with no concerns identified.

3) A review of chart audit records revealed all resident records were reviewed for falls, behaviors, accidents, abuse, Physician orders, 24 hour reports, and notifications of the Physician, POA or family for any resident status change by 12/17/14. No concerns were identified.

4) Review of training records revealed the Administrator, DON, Nursing Supervisors, MDS Coordinator, Staff Development Coordinator, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Human Resources staff, and designated Charge Nurses were re-educated beginning on 12/15/14 and completed on 12/16/14 by the Regional Nurse Consultant. Topics covered included the Abuse Policy, investigations, care planning, notification of the Physician and family, and utilization of the 24 hour report to inform of a change in a resident's condition. Further review of documentation revealed all completed the post test with a 100% score.

Interviews with thirteen (13) administrative staff, including the Dietary Manager on 12/30/14 at 12:10 PM, the Registered Dietitian on 12/30/14 at 12:00 PM, the Director of Plan Operations on 12/30/14 at 3:00 PM, the SSD on 12/30/14 at 3:15 PM, Social Worker #2 on 12/30/14 at 3:30 PM, Charge Nurse #3 on 12/31/14 at 8:30 AM, Charge Nurse #2 on 12/31/14 at 9:15 AM, Unit Manager #1 on 12/31/14 at 9:15 AM, the DON on 12/31/14 at 10:30 AM, the Administrator on

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F 157	<p>Continued From page 17</p> <p>12/31/14 at 10:45 AM, the SDC on 12/31/14 at 12:40 PM, the Chaplain on 12/31/14 at 1:00 PM and the Rehabilitation Manager on 12/31/14 at 1:00 PM revealed all were re-educated on performing a thorough investigation, reporting, updating care plans, the facility policy on incidents and accidents, the 24 hour report policy and notifications by the Regional Nurse Consultant and completed a post-test.</p> <p>5) Further review of training records revealed all facility staff was re-educated on the facility's Abuse Policy, including identification and reporting, between 12/15/14 and 12/19/14. The training was provided by the DON, Administrator and the SDC.</p> <p>Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed Practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational Therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed all received re-education by the DON, SDC, Administrator and Charge Nurses on identifying, reporting and investigating abuse. In addition, all interviewees stated they were required to</p>	F 157	

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complete the post-test with 100% accuracy prior to returning to work.

Review of the Certified letter revealed it was sent on 12/19/14 to all PRN (as needed) staff and all staff on vacation or medical leave. The letter informed the recipient to contact the DON or the SDC to complete mandatory in-services prior to their next shift.

6) Review of post-tests dated 12/15/14 -12/30/14 revealed ten (10) facility staff were receiving rotating tests daily. All completed tests were scored at 100%.

Interview with the DON, on 12/31/14 at 10:30 AM, revealed she coordinated with the Administrator, SDC and nursing Unit Managers for continuing staff education related to the abuse policy.

Interview with the Registered Dietitian, on 12/30/14 at 12:00 PM, revealed the department managers were responsible for administering abuse quizzes to assigned staff.

Interview with the Dietary Manager, on 12/30/14 at 12:10 PM, revealed she had an assigned day for assessing staff knowledge about abuse.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on

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F 157	<p>Continued From page 19</p> <p>12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed they had received two (2) to three (3) quizzes per week to assess their retention and understanding of the information provided during the initial in-service.</p> <p>7) A review of the Human Resources audit forms revealed twenty (20) newly hired staff since 10/22/14 were reviewed for any abuse concerns. The audits included a re-check of the Nurse Aide Abuse Registry to ensure no staff appeared on the Registry. Audit results were signed and dated as reviewed by the RNC on 12/17/14. No concerns were identified.</p> <p>8) Review of the AOC binder revealed forty-one (41) grievances, dated 11/15/14 to 12/15/14, were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors, Regional Nurse Consultant on 12/16/14 with no concerns. Interview with the Administrator on 12/31/14 at 10:50 AM confirmed she had reviewed the grievances and that the grievances were continually reviewed daily from 12/16/14 to 12/30/14 to identify any reportable allegations which were not identified on the initial review.</p> <p>9) Review of AOC binder revealed fifty-nine (59) incident reports, dated 11/15/14 to 12/15/14, were reviewed by the DON, Assistant Director of Nursing, Staff Development Coordinator and Regional Nurse consultant with no concerns</p>	F 157			

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10) Review of the daily sign off sheets, dated 12/15/14 -12/31/14 revealed the Regional Nurse Consultant was present daily at the facility.

11) Record review of walking rounds documentation, dated 12/15/14 to 12/30/14, revealed they were completed daily by the Administrator, DON, Nursing Supervisors, and Department Heads. The rounds included a physical assessment by the nurse for five (5) residents with a BIMS score <8, and interviews with five (5) residents with a BIMS score >8, concerning how the residents were treated by facility staff. In addition, nurses and SRNA's were interviewed regarding any changes in resident behaviors. Review of the QA meeting minutes revealed all results of resident and staff interviews, and skin assessments, were discussed during the weekly QA meetings.

12) Review of the Resident Status Monitoring Forms revealed they were completed daily by the Administrator, DON and Department Heads during walking rounds. The form included staff interviews, review of the 24 Hour Report sheet, observations of residents for documented behaviors, and identification of reportable incidents with evidence of a report to administration. Continued review revealed the DON conducted a follow-up daily to ensure Physician orders and ten (10) resident records were reviewed daily to ensure appropriate notifications and care plan revisions were made. The audits were reviewed, signed and dated daily by the Administrator.

13) Review of the AOC binder revealed it

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contained documented evidence the Administrator, DON, Social Services and RNC reviewed all resident interviews, assessments, and staff questionnaires daily between 12/15/14 and 12/31/14, with no identified concerns.

F 157

14) Review of Abuse Log forms, dated 12/15/14-12/31/14, revealed the Administrator, DON and Social Service Director reviewed abuse allegations daily to track and trend for any additional needed interventions by the QA committee. All allegations were reviewed to ensure protection of residents by removal of the perpetrator, timeliness of reporting to the State Survey Agency, and initiation and completion of thorough investigations. Interview with the Administrator on 12/31/14 at 11:10 AM confirmed she would reviewed the abuse investigations and there were no new abuse allegations made during this period.

15) Review of the Abuse Log and review of documented daily walking rounds of the Administrator, DON and Department Heads, from 12/15/14 to 12/30/14, revealed no new abuse allegations or incidents suspicious for abuse were identified.

16) Review of the AOC binder and interview with the DON, on 12/31/14 at 1:00 PM, revealed no care plan conferences had taken place between 12/16/14 and 12/31/14. The DON stated the facility's plan for care plan conferences included discussion with the resident and/or family regarding any concerns they had about abuse. In addition, the DON stated during the meetings, education would be provided related to abuse, e.g. what abuse is and how to report abuse.

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17) Review of the daily tracking form dated 12/16/14-12/30/14 revealed administrative oversight was provided by the RNC, onsite daily throughout the period.  
  
18) Review of the QA minutes for the weekly meetings dated 12/15/14, 12/19/14 and 12/24/14 revealed the Plan of Action for the cited deficiencies was discussed each time. Any changes to the QA Plan of Action were to be in bold print. No changes were made during these weekly meetings. Interview with the Administrator, on 12/31/14 at 10:20 AM, revealed if any changes were determined to be necessary, they would be reviewed by the entire QA team and communicated to facility staff. Continued interview with the Administrator revealed the QA weekly committee meetings consisted of all Department Heads, Unit Managers, Chaplain, Medical Director, Social Worker, Dietitian, Administrator and DON.

F 157

F 223 SS=J 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION

F 223

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 facility policy, it was determined the facility failed to have an effective system to protect one (1) of

Past noncompliance: no plan of correction required.

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five (5) sampled residents from abuse (Resident #2).

Interview and record review revealed Resident #1 had a history of exhibiting sexual behaviors towards residents and staff, including touching female breasts and buttocks. On 12/13/14 at 11:15 AM Housekeeper #1 and Housekeeper #2 witnessed Resident #1 touching Resident #2 on his/her thigh between the legs. The housekeepers informed State Registered Nurse Aide (SRNA) #1, who separated the residents and informed Registered Nurse (RN) #4/Weekend Supervisor of the observed incident. RN #4 instructed RN #3/Charge Nurse to have Housekeeper #1 and Housekeeper #2 provide written witness statements. Although Resident #1 and Resident #2 were separated, no physical assessment was completed for Resident #2; there was no documented evidence the facility implemented increased supervision of Resident #1; and, information concerning the incident was not passed on to subsequent shifts, verbally or in writing to protect the residents.

On 12/14/14 RN #1 heard Resident #2 talking about being touched. As RN #1 had not received any report of the incident on 12/13/14, she assumed Resident #2 was speaking about something that happened in the past. RN #1 failed to report the concerns voiced by Resident #2. On 12/15/14, Resident #1 touched Resident #2 again. Resident #2 yelled out, pointed a finger at Resident #1, and stated Resident #1 had touched his/her breast and was "naughty" for doing so.

The facility's failure to ensure residents were protected from abuse was likely to cause serious

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injury, harm, impairment death. Immediate Jeopardy was identified on 12/23/14, and was determined to exist on 12/13/14. The facility was notified of the Immediate Jeopardy on 12/24/14.

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An acceptable credible Allegation of Compliance (AOC) was received on 12/29/14. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected on 12/20/14 prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

The findings include:

Review of the facility's policy titled "Abuse, Neglect and Misappropriation", effective date 04/2013, revealed verbal, sexual, physical and mental abuse were prohibited. Further review of the policy revealed for incidents of abuse by a resident toward another resident, the following steps were required: complete a physical assessment to determine any potential injuries; notify the DON or Administrator immediately; and, provide close supervision of the residents.

Review of the facility's policy titled "24 Hour Report", effective date 12/2010, revealed the 24 Hour Report was used to provide communication between nursing, administration and direct care departments concerning changes in residents' status. Licensed nurses were to list residents on the 24 Hour Report to inform of acute changes in behavior, mental status or physical conditions and any incidences, skin changes or injuries.

Clinical record review revealed the facility admitted Resident #1 on 05/09/14 with diagnoses which included Psychosis, Dementia, Behavioral

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Disturbance, Anxiety, and Mood Dysregulation. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/31/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident was severely cognitively impaired and not interviewable.

Review of the Comprehensive Care Plan, dated 05/19/14, revealed Resident #1 was assessed to be at risk for behavioral problems including yelling out, resident to resident altercations, and sexual behaviors. The stated goal was "resident will have fewer episodes through next review". Continued review revealed interventions in place on 12/13/14 were as follows: reinforce positive behavior; administer medications for depression, psychosis, and sexual behaviors; and observation by staff.

Review of the Behavioral Assessment, dated 05/28/14 and updated 08/07/14, revealed Resident #1 had a history of behavioral symptoms, including the following: sticking his/her middle finger up at others; asking a visitor for a "blow job"; and sexual behaviors toward other residents and staff, including touching female breasts and buttocks. Continued review revealed Resident #1 was placed on increased monitoring for the exhibited behaviors, one to one 1:1 supervision or every fifteen (15) minutes, on seven (7) different occasions between 05/28/14 and 10/31/14. On 12/12/14, Resident #1 was placed on every fifteen (15) minute checks due to a "negative statement".

Review of the clinical record revealed the facility admitted Resident #2 on 01/15/14 with diagnoses which included Dementia and Hypertension.

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F 223	<p>Continued From page 26</p> <p>Review of the annual MDS assessment, dated 11/17/14, revealed Resident #2 was assessed by the facility to have a BIMS score of 3, which indicated the resident was severely cognitively impaired and not interviewable.</p> <p>Interview with SRNA #1, on 12/23/14 at 3:30 PM, revealed on 12/13/14 at approximately 11:15 AM, Housekeepers #1 and #2 reported to her they saw Resident #1 touch Resident #2 on the inner thigh area. Continued interview revealed although she did not actually witness the incident, she did separate Residents #1 and #2 after she was told of it by the housekeepers. SRNA #1 revealed she reported what the housekeepers had told her to RN #4/Weekend Supervisor.</p> <p>Interview with Housekeeper #2, on 12/24/14 at 3:31 PM, revealed she saw Resident #1 touch Resident #2 between the legs on 12/13/14. She stated she provided a written statement for RN #3.</p> <p>Interview with Housekeeper #1, on 12/24/14 at 12:15 PM, revealed she was in the hall at 11:15 AM on 12/13/14, and saw Resident #1 touch Resident #2 between the legs. She stated she informed SRNA #1, and provided a written statement for RN #3.</p> <p>Telephone interview with RN #3, on 12/24/14 at 3:00 PM, revealed on 12/13/14 Housekeepers #1 and #2 reported Resident #1 touched Resident #2 between the thighs. She stated she took the housekeepers' written statements and gave them to RN #4. Continued interview revealed she thought RN #4, who was the Supervisor, would contact the DON. She further stated she should have performed a skin assessment for Resident</p>	F 223		
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F 223	<p>Continued From page 27 #2 after the incident.</p> <p>Telephone interview with RN #4, on 12/24/14 at 2:50 PM, revealed he was the Supervisor on the weekend of 12/13/14. He stated Housekeepers #1 and #2 witnessed Resident #2 touch Resident #1 between the legs. He asked RN #3 to take a written statement from the housekeepers related to what they had witnessed. RN #4 further stated all he did was place the written statements on the Unit Manager's desk.</p> <p>Review of Resident #1's Nurses Notes for 12/13/14 revealed no documented account of the incident between Resident #1 and Resident #2. Continued review revealed the only entry for 12/13/14 was made at 6:15 PM by RN #4, who documented Resident #1 had "no aggressive or inappropriate behaviors noted this shift", which included the time of the incident that morning. However, per interview, RN #4 was aware Resident #1 had touched Resident #2 between the legs.</p> <p>Interview with RN #1, on 12/23/14 at 2:57 PM, revealed she overheard Resident #2 having a conversation with his/her family on 12/14/14, and heard Resident #2 say Resident #1 "touched" him/her. RN #1 stated she did not work on 12/13/14, and had not received any information through report on 12/14/14, regarding an incident which occurred on 12/13/14, concerning the alleged abuse and assumed Resident #2 was speaking of something from the past, as the resident had a history of speaking of past events.</p> <p>Continued review of Resident #1's medical record revealed a Nurse's Note dated 12/15/14, timed 7:10 AM, written by RN #1, revealed it was a "late</p>	F 223		

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entry" Note made for 12/14/14 at 3:10 PM. Per the "late entry" Note, RN #1 documented another resident who was present in the lobby, with Resident #1 and other residents and staff, "approached" her, and stated Resident #1 was "touching" him/her and pointed at Resident #1. Continued review of the "late entry" Note revealed two (2) other residents in the lobby at the time, "agreed" with the "allegations of inappropriate behavior/physical contact". Per review of the "late entry" Note, RN #1 documented SRNA's "on duty who worked day shift the previous day (Saturday 12/13/14)" informed RN #1, Resident #1 had "behaviors" on "Saturday", 12/13/14. Further review of the "late entry" Note revealed the SRNA's also reported "housekeepers who witnessed" Resident #1's behaviors on 12/13/14, had "filled out statements"; however, RN #1 was unable to locate them. In addition, review of the "late entry" Note revealed RN #1 was unable to contact the RN who had worked day shift on 12/13/14. However, further review of the "late entry" Note revealed no documented evidence of RN #1 overhearing Resident #2 in conversation with visitors, saying Resident #1 had touched him/her.

Further interview with RN #1, on 12/23/14 at 2:57 PM, revealed on 12/15/14 Resident #1 and #2 were sitting close, in their wheel chairs, in front of the nurses station on the Cherry Blossom unit when Resident #2 yelled out about being touched and stated Resident #1 was "naughty" and had touched his/her breast.

Review of the Incident Report, dated 12/15/14 at 8:00 AM, revealed Resident #2 alleged Resident #1 touched him/her on the breast while sitting in the lobby of the Cherry Blossom Unit.

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Further review of the Nurses Notes for Resident #1, dated 12/15/14 at 8:15 AM, revealed a resident in the lobby started screaming Resident #1 "is touching me".

Review of the Nurses Notes for Resident #2 revealed no documentation related to an allegation of abuse until 12/15/14.

Interview on 12/23/14 at 10:40 AM, with Resident #3 assessed by the facility to have a BIMS of 15 indicating the resident was cognitively intact and interviewable, revealed he/she saw Resident #1 touch Resident #2 on the breast but could not recall the day. Resident #3 stated he/she was sitting in the lounge area in front of the nurses station when Resident #1 rolled over to Resident #2. Continued interview revealed Resident #1 watched the nurses' desk to see if anyone was looking, then touched Resident #2 on the breast and rolled back in his/her wheelchair. Further interview revealed Resident #1 looked like he/she was laughing and possibly knew right from wrong. Resident #3 stated Resident #1 was "slick and sneaky", and staff did not witness the incident.

Interview with the DON, on 12/31/14 at 10:10 AM, revealed she was not aware of the incident on 12/13/14 until after the incident on 12/15/14 was reported. She stated it was her expectation that staff follow the facility's Abuse Policy and immediately report any allegation of abuse, or signs and symptoms of abuse, to the Charge Nurse.

A post-survey interview with the Administrator on 01/15/15 at 11:25 AM, revealed after the incident on 12/13/14 was reported to the Charge Nurse

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and she informed the Weekend Supervisor, one (1) of them should have notified her, the DON, Abuse Coordinator and SS. According to the Administrator, the Charge Nurse did not fully inform the Weekend Supervisor of what had occurred, but she would have expected him to have gotten the specifics. Continued interview revealed the incident should have been documented on the "24 Hour Report" and passed along to other nurses in their verbal shift report. She stated if that had been done "some type of follow up could have been done", and it was a possibility had she been notified on 12/13/14, the other incident on 12/15/14 "might not have occurred".

The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/29/14, which alleged removal of the IJ effective 12/20/14. Review of the AOC revealed the facility implemented the following corrective actions:

1) The allegation of resident to resident inappropriate touching on 12/13/14, was reported to the State Survey Agency, the Physician and the Power of Attorney (POA) for both residents on 12/16/14. A thorough investigation was initiated on 12/15/14 and concluded on 12/19/14 by the Administrator, the DON and Social Services. A five (5) day report was sent to the State Survey Agency and Adult Protective Services on 12/19/14. The Comprehensive Care Plans for Residents #1 and #2 were updated with appropriate interventions to meet each resident's care needs on 12/15/14 by the DON, Nursing Supervisors, or MDS Coordinator. Resident #2 was assessed on 12/15/14 by the Charge Nurse with no concerns noted. One to one (1:1) education was provided to RN #4 and RN #3 by

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the Administrator and the Regional Nurse Consultant by 12/19/14. Resident #1 was placed on 1:1 observation when out of bed and every fifteen (15) minute checks while in bed and a consult for psychiatric services was initiated. Social Services was consulted for follow-up with Resident #2 for psychosocial support and to identify any concerns for Resident #2.

2) All residents were assessed for any signs and symptoms of abuse/neglect. Residents with a BIMS score >8 were interviewed by the Social Services Director, Chaplain, Registered Dietitian, Human Resources, Environmental Director, Unit Managers, Nursing Supervisors, Admissions personnel, Restorative Nurse, Physician's nurses or the Administrator for any abuse/neglect concerns on 12/15/14. Residents with a BIMS score <8 were physically assessed by the nursing supervisors for any signs and symptoms of abuse/neglect. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator or the Regional Nurse Consultant (RNC) on 12/16/14 for any indications of abuse/neglect. No concerns were identified.

3) All resident charts were reviewed for any status changes in the past thirty (30) days by the DON, Nursing Supervisors, Unit Manager, Staff Development Coordinator (SDC), MDS staff, Medical Records personnel, Marketing/Admissions personnel, Social Service Director (SSD) or the RNC by 12/17/14 to ensure Physician and POA notifications were made and care plans were updated appropriately to reflect current resident care needs. No issues were identified.

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4) Re-education on implementation of the Abuse Policy was provided by the Regional Nurse Consultant on 12/15/14 and 12/16/14 for the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, Recreational Staff Manager, Medical Records, Human Resources, and designated charge nurses. Educational topics included: performing a thorough investigation; immediate reporting; updating the care plans according to facility policy; review of the policy related to accidents and incidents; review of the 24 Hour Report Policy; and notification of Physicians and family. The training was face-to-face to facilitate discussion. Examples of reportable incidents were discussed and a written post-test was administered. Those educated could not return to work until 100% score on the post-test was achieved.

5) After re-education by the RNC, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Services Manager, Medical Records personnel, and designated Charge Nurses were assigned to re-educate all staff. This education was initiated on 12/15/14 and completed on 12/19/14. Any staff who were on leave or had not completed the education by 12/19/14 was sent a certified letter informing them they could not return to work until they received the training. Each staff member was required to score 100% on the written post-test prior to returning to work. In addition, all newly-hired staff will be required to complete abuse training and score 100% on the

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post-test before beginning their job duties.

6) Beginning 12/15/14, post-tests will be administered to ten (10) different staff daily, to include all shifts. Two (2) different tests will be utilized on alternating days to ensure ongoing retention and understanding of the provided abuse education. The tests will be administered by the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Environmental Services Director or Human Resources staff.

7) Human Resources personnel will audit all new employees hired since 10/22/14 for any abuse concerns. A total of twenty (20) new employees were reviewed. Audit results were reviewed by the RNC, Clinical Compliance Nurse or the Vice President of Operations on 12/17/14. No concerns were identified.

8) All grievances dated 11/15/14 to 12/15/14, and all new grievances beginning on 12/16/15 were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors or Regional Nurse Consultant to ensure all reportable allegations had been identified. A total of forty-one (41) grievances were reviewed.

9) All incident reports from 11/15/14 to 12/15/14 were reviewed by the DON, Assistant DON, SDC or RNC on 12/16/14 to identify any concerns of suspected neglect. A total of fifty-nine (59) reports were reviewed and no concerns were identified.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/31/2014</b>
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10) Beginning 12/15/14, a nurse from the regional team or corporate office will be onsite daily until the IJ is lifted. The nurses will assist with investigations, observations of staff treatment of residents, perform chart audits and provide oversight and consultation.

11) The Administrator, DON, Nursing Supervisors and Department Heads will be onsite daily and make walking rounds of the facility. Five (5) residents with a BIMS score >8 will be interviewed and five (5) residents with a BIMS score <8 will be physically assessed for abuse concerns. In addition, staff assigned to the residents will be questioned regarding any behavioral changes exhibited by the residents. This will continued until the IJ is lifted. Then, three (3) residents with a BIMS score >8 and three (3) resident with a BIMS score <8 will be interviewed or assessed daily for four (4) weeks. All results will be reported at the weekly Quality Assurance (QA) meeting. At the end of the four (4) weeks, the QA committee will determine at what frequency the interviews, assessments and staff questionnaires need to continue. Any concerns identified will be addressed immediately, reported to the Administrator and an investigation initiated.

12) Beginning 12/16/14 and continuing until the IJ is lifted, the Administrator, DON, Nursing Supervisors, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, or Human Resources will be on site daily to complete the Resident Status Monitoring Form. Completion of the form requires staff interviews, review of the 24 hour

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sheet, observations for documented behaviors, walking rounds with visualization of all residents, identification of any reportable incidents and reporting to the Charge Nurse and Administrator for any identified incidents. Also, the DON will daily review Physician orders to ensure appropriate notifications are made and care plans are updated, review the 24 hour sheets for any resident status changes, review ten (10) resident charts for any status changes without appropriate notifications and care plan updates, and initiate reporting and investigation of any accidents/incidents that are reported. All results will be reported at the weekly QA meeting. After removal of the IJ, the committee will determine at what frequency the Resident Status Monitoring form needs to be completed.

13) Beginning 12/15/14, the Administrator, DON, and Social Services or a member of the regional staff will review all resident interviews, assessments and staff questionnaires daily for any concerns, and initiate an investigation as indicated.

14) The Administrator, DON, and Social Services Director will review and discuss all abuse investigations daily, starting on 12/15/14, to ensure that the resident is protected, the perpetrator is removed from the resident care area, reports to the State Survey Agency are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log, and along with regional staff will review the log daily to ensure the above.

15) In the event of any new report of alleged abuse, neglect or misappropriation of property, the regional office will be notified within

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twenty-four (24) hours and again at the conclusion of the investigation to ensure a thorough investigation is completed and reporting timelines are met.

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16) During Care Plan conferences with residents and families, abuse/neglect concerns will be discussed. In addition, education related to abuse, including reporting, will be provided with supporting documentation.

17) Beginning 12/15/14, administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or a member of the regional staff daily until removal of the IJ, then weekly for four (4) weeks, then monthly.

18) Beginning 12/15/14, a QA meeting will be held weekly until the IJ is removed, then for four (4) more weeks, then monthly. During these meetings, the QA committee will review and evaluate the stated plan, make recommendations for plan revisions or re-education needs as identified, and determine at what frequency ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all facility staff.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1) Review of the State Agency Intake form revealed the initial facility report was received on 12/15/14 with additional information provided on 12/16/14. Continued review revealed the facility

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submitted a final report of their investigation on 12/19/14.

Review of two (2) Incident Reports, one for Resident #1 and one for Resident #2, revealed the Physician and the POA for each resident were notified by the facility on 12/15/14.

Review of the Comprehensive Care Plan for Resident #1 revealed it was updated on 12/15/14 to include the following interventions: 1:1 observation of the resident when out of bed, with every fifteen (15) minute checks while in bed; consult to Psychiatric Services; and a medication review.

Review of the Comprehensive Care Plan for Resident #2 revealed revised interventions included: report changes in mood status to the Physician; support the resident's strengths and coping skills; and encourage expression of feelings.

Review of the Nurses Note dated 12/15/14 at 9:00 AM, revealed Resident #2 was assessed by the Charge Nurse with no signs of physical contact, bruising, redness or swelling identified.

Interview with the DON, on 12/24/14 at 4:15 PM, revealed RN #4 and RN #3 received 1:1 education on 12/15/14 related to their responsibilities when abuse was alleged. Review of education records revealed both nurses did receive the training and had completed post-tests with a 100% passing score.

Review of the Resident Monitoring Tool for the dates of 12/15/14 through 12/30/14 revealed Resident #1 was on 1:1 observation when out of

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the bed, and every fifteen (15) minute observations were made when the resident was in bed.

Further review of the Comprehensive Care Plan for Resident #1 revealed a consult was placed with the facility's contracted Psychiatric Services.

Review of Social Services notes, dated 12/15/14 through 12/19/14, revealed Residents #1 and #2 were followed daily. Discussion with Resident #1 included education related to inappropriate behaviors and ongoing support for the resident and the spouse. Resident #2 was assessed daily for mood changes. The Social Worker documented no psychosocial concerns were identified for either resident.

2) Review of the facility's AOC binder, which contained documents related to the corrective actions, revealed all residents were assessed for signs and symptoms of abuse/neglect on 12/15/14. Residents with a BIMS score >8 were interviewed related to any abuse/neglect concerns by the Social Services Director, Chaplain, Registered Dietitian, Unit Managers and Nursing Supervisors. Residents with a BIMS score <8 were physically assessed for any signs or symptoms of abuse by the Nursing Supervisors. A review of the audits, assessments, and interviews utilized revealed not identified concerns.

Interview with the Administrator on 12/31/14 at 10:30 AM revealed she reviewed all of the resident interviews and assessments on 12/16/14 with no concerns identified.

3) A review of chart audit records revealed all

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resident records were reviewed for falls, behaviors, accidents, abuse, Physician orders, 24 hour reports, and notifications of the Physician, POA or family for any resident status change by 12/17/14. No concerns were identified.

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4) Review of training records revealed the Administrator, DON, Nursing Supervisors, MDS Coordinator, Staff Development Coordinator, Director of Dining Services, Business Office Manager, SSD, Central Supply, Chaplain, Marketing/Admissions personnel, Recreational Staff Manager, Medical Records personnel, Human Resources staff, and designated Charge Nurses were re-educated beginning on 12/15/14 and completed on 12/16/14 by the Regional Nurse Consultant. Topics covered included the Abuse Policy, investigations, care planning, notification of the Physician and family, and utilization of the 24 hour report to inform of a change in a resident's condition. Further review of documentation revealed all completed the post test with a 100% score.

Interviews with thirteen (13) administrative staff, including the Dietary Manager on 12/30/14 at 12:10 PM, the Registered Dietitian on 12/30/14 at 12:00 PM, the Director of Plan Operations on 12/30/14 at 3:00 PM, the SSD on 12/30/14 at 3:15 PM, Social Worker #2 on 12/30/14 at 3:30 PM, Charge Nurse #3 on 12/31/14 at 8:30 AM, Charge Nurse #2 on 12/31/14 at 9:15 AM, Unit Manager #1 on 12/31/14 at 9:15 AM, the DON on 12/31/14 at 10:30 AM, the Administrator on 12/31/14 at 10:45 AM, the SDC on 12/31/14 at 12:40 PM, the Chaplain on 12/31/14 at 1:00 PM and the Rehabilitation Manager on 12/31/14 at 1:00 PM revealed all were re-educated on performing a thorough investigation, reporting,

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updating care plans, the facility policy on incidents and accidents, the 24 hour report policy and notifications by the Regional Nurse Consultant and completed a post-test.

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5) Further review of training records revealed all facility staff was re-educated on the facility's Abuse Policy, including identification and reporting, between 12/15/14 and 12/19/14. The training was provided by the DON, Administrator and the SDC.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed Practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational Therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at 9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed all received re-education by the DON, SDC, Administrator and Charge Nurses on identifying, reporting and investigating abuse. In addition, all interviewees stated they were required to complete the post-test with 100% accuracy prior to returning to work.

Review of the Certified letter revealed it was sent on 12/19/14 to all PRN (as needed) staff and all

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staff on vacation or medical leave. The letter informed the recipient to contact the DON or the SDC to complete mandatory in-services prior to their next shift.

6) Review of post-tests dated 12/15/14 -12/30/14 revealed ten (10) facility staff were receiving rotating tests daily. All completed tests were scored at 100%.

Interview with the DON, on 12/31/14 at 10:30 AM, revealed she coordinated with the Administrator, SDC and nursing Unit Managers for continuing staff education related to the abuse policy.

Interview with the Registered Dietitian, on 12/30/14 at 12:00 PM, revealed the department managers were responsible for administering abuse quizzes to assigned staff.

Interview with the Dietary Manager, on 12/30/14 at 12:10 PM, revealed she had an assigned day for assessing staff knowledge about abuse.

Interviews with Housekeeper #3 on 12/30/14 at 11:35 AM, Floor Tech #4 on 12/30/14 at 11:45 AM, Cook #1 on 12/30/14 at 11:50 AM, Cook #2 on 12/30/14 12:00 PM, Licensed practical Nurse (LPN) #2 on 12/30/14 at 12:15 PM, Occupational therapist #1 on 12/30/14 at 12:35 PM, Speech Therapist #2 on 12/30/14 at 12:50 PM, Dietary Aide #1 on 12/30/14 at 2:35 PM, Housekeeper #5 on 12/30/14 at 2:55 PM, Housekeeper #6 on 12/30/14 at 3:25 PM, Maintenance worker #1 on 12/30/14 at 3:35 PM, SRNA #6 on 12/31/14 at 8:45 AM, SRNA #5 on 12/31/14 at 8:50 AM, Dietary Aide #3 on 12/31/14 at 9:30 AM, Dietary Aide #2 on 12/31/14 at 9:35 AM, SRNA #8 on 12/31/14 at 9:30 AM, SRNA #7 on 12/31/14 at

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9:40 AM, SRNA #9 on 12/31/14 at 9:45 AM, SRNA #10 on 12/31/14 at 9:55 AM, and the MDS Coordinator on 12/31/14 at 10:10 AM revealed they had received two (2) to three (3) quizzes per week to assess their retention and understanding of the information provided during the initial in-service.

7) A review of the Human Resources audit forms revealed twenty (20) newly hired staff since 10/22/14 were reviewed for any abuse concerns. The audits included a re-check of the Nurse Aide Abuse Registry to ensure no staff appeared on the Registry. Audit results were signed and dated as reviewed by the RNC on 12/17/14. No concerns were identified.

8) Review of the AOC binder revealed forty-one (41) grievances, dated 11/15/14 to 12/15/14, were reviewed by the Administrator, DON, Chaplain, Nurse Supervisors, Regional Nurse Consultant on 12/16/14 with no concerns. Interview with the Administrator on 12/31/14 at 10:50 AM confirmed she had reviewed the grievances and that the grievances were continually reviewed daily from 12/16/14 to 12/30/14 to identify any reportable allegations which were not identified on the initial review.

9) Review of AOC binder revealed fifty-nine (59) incident reports, dated 11/15/14 to 12/15/14, were reviewed by the DON, Assistant Director of Nursing, Staff Development Coordinator and Regional Nurse consultant with no concerns identified.

10) Review of the daily sign off sheets, dated 12/15/14 -12/31/14 revealed the Regional Nurse Consultant was present daily at the facility.

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11) Record review of walking rounds documentation, dated 12/15/14 to 12/30/14, revealed they were completed daily by the Administrator, DON, Nursing Supervisors, and Department Heads. The rounds included a physical assessment by the nurse for five (5) residents with a BIMS score <8, and interviews with five (5) residents with a BIMS score >8, concerning how the residents were treated by facility staff. In addition, nurses and SRNA's were interviewed regarding any changes in resident behaviors. Review of the QA meeting minutes revealed all results of resident and staff interviews, and skin assessments, were discussed during the weekly QA meetings.

12) Review of the Resident Status Monitoring Forms revealed they were completed daily by the Administrator, DON and Department Heads during walking rounds. The form included staff interviews, review of the 24 Hour Report sheet, observations of residents for documented behaviors, and identification of reportable incidents with evidence of a report to administration. Continued review revealed the DON conducted a follow-up daily to ensure Physician orders and ten (10) resident records were reviewed daily to ensure appropriate notifications and care plan revisions were made. The audits were reviewed, signed and dated daily by the Administrator.

13) Review of the AOC binder revealed it contained documented evidence the Administrator, DON, Social Services and RNC reviewed all resident interviews, assessments, and staff questionnaires daily between 12/15/14 and 12/31/14, with no identified concerns.

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14) Review of Abuse Log forms, dated 12/15/14-12/31/14, revealed the Administrator, DON and Social Service Director reviewed abuse allegations daily to track and trend for any additional needed interventions by the QA committee. All allegations were reviewed to ensure protection of residents by removal of the perpetrator, timeliness of reporting to the State Survey Agency, and initiation and completion of thorough investigations. Interview with the Administrator on 12/31/14 at 11:10 AM confirmed she would reviewed the abuse investigations and there were no new abuse allegations made during this period.

15) Review of the Abuse Log and review of documented daily walking rounds of the Administrator, DON and Department Heads, from 12/15/14 to 12/30/14, revealed no new abuse allegations or incidents suspicious for abuse were identified.

16) Review of the AOC binder and interview with the DON, on 12/31/14 at 1:00 PM, revealed no care plan conferences had taken place between 12/16/14 and 12/31/14. The DON stated the facility's plan for care plan conferences included discussion with the resident and/or family regarding any concerns they had about abuse. In addition, the DON stated during the meetings, education would be provided related to abuse, e.g. what abuse is and how to report abuse.

17) Review of the daily tracking form dated 12/16/14-12/30/14 revealed administrative oversight was provided by the RNC, onsite daily throughout the period.