

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2013
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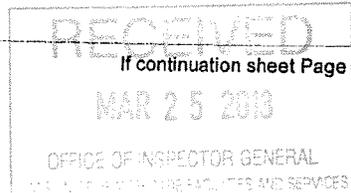
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223
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F 000	INITIAL COMMENTS	F 000		
F 224 SS=E	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review it was determined the facility failed to protect residents of the facility from abuse for one (1) of three (3) sampled residents. A facility staff person, CNA #1, was accused of verbal abuse and neglect by Resident #1.</p> <p>The findings include: Review of the facility's policy regarding Abuse Prohibition, not dated, revealed residents had the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Review of the clinical record for Resident #1 revealed the facility admitted the resident on</p>	F 224	<p>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."</p> <p>F224</p> <ol style="list-style-type: none"> Resident #1 was assisted with her personal care needs by CNA#2 and CNA #1 did not care for Resident #1 after the reported incident on 2-25-13. CNA#1 was removed from duty on 2-26-13 and has not returned to work. Acting Administrator reviewed all reports of abuse completed over the previous 6 months to ensure appropriate interventions were taken by staff. This was completed on March 7, 2013. On 2-27-13 facility initiated interviews with interviewable residents assigned to CNA#1 to ensure no other resident had been affected by employee's behavior. Social Services and ADON to interview all interviewable 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Dianne Conwell</i>	TITLE <i>X Acting Administrator</i>	(X6) DATE <i>X 3-25-13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

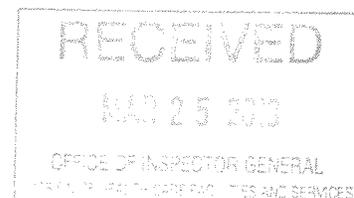


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F 224	Continued From page 1 10/04/12 with diagnoses of Vascular Dementia, Chronic Kidney Disease, Diabetes, Hypertension, Neurogenic Bladder, Depression, Osteoarthritis and Esophageal Reflux. The facility completed a Resident Assessment Instrument on 01/11/13 and scored a Brief Interview of Mental Status at 11, which indicated the resident was moderately impaired. Interview with Resident #1, on 03/05/13 at 10:35 AM, revealed he/she requested help getting undressed from CNA #1. When CNA #1 was helping him/her get undressed, she told the resident he/she was the reason staff were quitting. Resident #1 stated his/her feelings were hurt because prior to that time Resident #1 felt there was a good rapport between the two of them. Resident #1 had even sent a Valentine card to CNA #1, complimenting the care she provided to the residents. Resident #1 also reported CNA #1 helped set her up for a partial bath by unfastening his/her blouse and brief. CNA #1 then left Resident #1 to start washing up for bed and then CNA #1 took her dinner break. Resident #1 stated CNA #1 never came back. About fifteen to thirty minutes later CNA #2 came in the room. After the resident explained what happened CNA #2 left to get her supervisor. Once the Supervisor saw how Resident #1 had been left, she instructed CNA #2 to finish getting him/her dressed and put to bed. Resident #1 stated his/her blouse was opened and the brief was wet and hanging down in front of the wheelchair. Resident #1 stated the supervisor asked all kinds of questions about why he/she had been left partially exposed. Resident #1 reported CNA #1 had not been back in her room.	F 224	residents and for non-interviewable residents a family member will be interviewed to determine if any resident or family have experienced and/or observed any type of abuse or neglect that they have not reported. These interviews will begin on March 19, 2013 and will be completed by March 26, 2013. On March 19, 2013 the facility initiated staff interviews to determine if any employee had observed any type of resident abuse or neglect that they did not report. These interviews will be conducted by DON, and Director of Staff Development. Interviews will be completed by March 26, 2013. 3.A mandatory in-service on the Abuse Policy was presented by DON, ADON, Nurse Managers and Director of Staff Development beginning 3-1-13 and completed on 3-13-13.		



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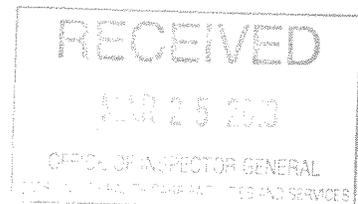
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F 224	<p>Continued From page 2</p> <p>Interview with CNA #2, on 03/05/13 at 3:09 PM, revealed on 02/25/13 about 8:30 PM she entered the room of Resident #1. She stated Resident #1's top was unzipped and she was exposed and the brief was open and hanging down in front of the wheelchair. Resident #1 told CNA #2 that CNA #1 had started his/her bath, but then left for her dinner break. Resident #1 told CNA #2 that was a long time ago. CNA #2 left and brought back the supervisor so she could see the condition Resident #1 had been left in. Once the supervisor saw the resident, CNA #2 changed Resident #1 and helped him/her to bed. CNA #2 stated CNA #1 came back from her dinner break and finished her shift.</p> <p>Interview with the Supervisor, on 03/05/13 at 3:25 PM, revealed CNA #2 reported to her that Resident #1 was upset and had been left in a mess. She went to the resident's room and found Resident #1 with his/her top open and breasts partially exposed and the brief was opened, flapped down in front of the wheelchair and it looked like it was wet. The Supervisor instructed CNA #2 to assist Resident #1 get cleaned up and put to bed.</p> <p>Interview with CNA #1, on 03/05/13 at 4:15 PM, revealed on 02/25/13 she was taking care of Resident #1. It was late and Resident #1 was getting ready for bed. She stated she unfastened Resident #1's blouse and released her brief and told the resident she would be back. She stated it normally took about thirty minutes for Resident #1 to wash up so she went for her dinner break. When she came back from dinner, CNA #2 told her Resident #1 was upset at being left undressed and her feelings were hurt by</p>	F 224	<p>In-service included review of Abuse Policy and Procedure including identification of abuse or neglect, types of abuse and neglect, investigation of abuse or neglect, including conducting staff interviews, the initial report, the 5 day report and need to arrive at a conclusion, also discussed protection of residents during the investigation.. To evaluate staff understanding a post test was given and was reviewed by the Director of Staff Development. .</p> <p>In-service for staff on Abuse Policy and Procedure will be repeated monthly for 3 months then no less than annually. All newly hired employees will be educated on the Abuse Policy during orientation. This will be the responsibility of the Director of Staff Development.</p>	
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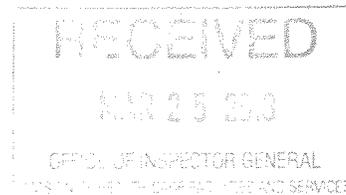
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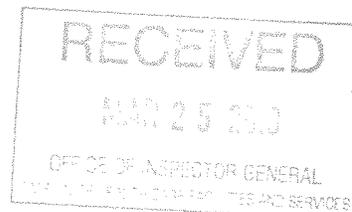
F 224	Continued From page 3 something she had said to him/her. Nothing more was said to her that night by anyone else. CNA #1 denied any abuse toward Resident #1 and stated she cared about Resident #1 and treated him/her like her own granny.	F 224		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to follow their policy on abuse. The supervisory staff allowed CNA #1 to continue to work with residents after an allegation of abuse had been made against her by one (1) of three (3) sampled residents. Resident #1. The findings include: Review of the facility's policy regarding Abuse Prohibition, not dated, revealed any individuals	F 226	4.All reports of Abuse will be reviewed by the Administrator monthly to ensure appropriate investigation and if indicated reporting is completed. Director of Social Services to interview each resident or if resident not interviewable, a family member or responsible party quarterly for 2 quarters on if they have observed or experienced any form of abuse or neglect that they have not reported. Director of Social Services to review the facility Policy on Abuse in the monthly Resident Council meeting scheduled for March 28, 2013and request feedback regarding any concerns related to abuse or neglect. Any concerns voiced will be immediately investigated and if appropriate reported to the appropriate agencies. Results of all audits and interviews will be reported to the facility QA Committee no less than quarterly for one year. Date of completion 3-29-13	



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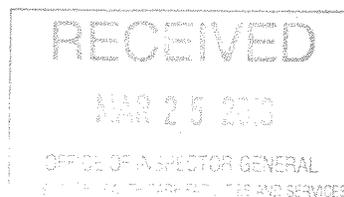
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F 226	Continued From page 4 suspected of causing abuse was to be removed from direct patient care and reassigned to non-patient care duties or suspended from duty until an investigation was completed and an administrative decision was made by the Administrator or governing body. Interview with Resident #1, on 03/05/13 at 10:35 AM, revealed he/she requested help getting undressed from CNA #1. When CNA #1 was helping him/her get undressed, she told the resident he/she was the reason staff were quitting. Resident #1 stated his/her feelings were hurt because prior to that time Resident #1 felt there was a good rapport between the two of them. Resident #1 had even sent a Valentine card to CNA#1, complimenting the care she provided to the residents. Resident #1 also reported CNA #1 helped set her up for a partial bath by unfastening his/her blouse and brief. CNA #1 then left Resident #1 to start washing up for bed and then CNA #1 took her dinner break. Resident #1 stated CNA #1 never came back. About fifteen to thirty minutes later CNA #2 came in the room. The resident explained what had happened and CNA #2 left to get her supervisor. Once the Supervisor saw how Resident #1 had been left, she instructed CNA #2 to finish getting him/her dressed and put to bed. Resident #1 stated his/her blouse was opened and the brief was wet and hanging down in front of the wheelchair. Resident #1 stated the supervisor asked all kinds of questions about why he/she had been left partially exposed. Resident #1 reported CNA #1 had not been back in her room. Interview with CNA #2, on 03/05/13 at 3:09 PM, revealed on 02/25/13 about 8:30 PM she entered	F 226	F226 1. Resident #1 was assisted with her personal care needs by CNA#2 and CNA #1 did not care for Resident #1 after the reported incident on 2-25-13. CNA#1 was removed from duty on 2-26-13 and has not returned to work. 2. Acting Administrator reviewed all reports of abuse completed over the previous 6 months to ensure appropriate interventions were taken by staff. This was completed on March 7, 2013. On 2-27-13 facility initiated interviews with interviewable residents assigned to CNA#1 to ensure no other resident had been affected by employee's behavior. Social Services and ADON to interview all interviewable	



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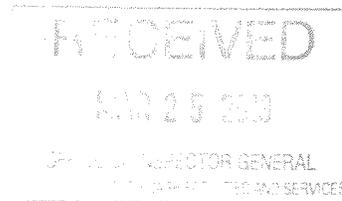
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F 226	Continued From page 5 the room of Resident #1. She stated Resident #1's top was unzipped and he/she was exposed and the brief was open and hanging in down in front of the wheelchair. Resident #1 told CNA #2 that CNA #1 had started his/her bath, but then left for her dinner break. Resident #1 told CNA #2 that was a long time ago. CNA #2 left and brought back the supervisor so she could see the condition Resident #1 had been left in. Once the supervisor saw the resident, CNA #2 changed Resident #1 and helped him/her to bed. CNA #2 stated CNA #1 came back from her dinner break and finished her shift. Interview with the Supervisor, on 03/05/13 at 3:25 PM, revealed CNA #2 reported to her that Resident #1 was upset and had been left in a mess. She went to the resident's room and found Resident #1 with his/her top open and breasts partially exposed and the brief was opened, flapped down in front of the wheelchair and it looked like it was wet. The Supervisor instructed CNA #2 to assist Resident #1 get cleaned up and put to bed. The Supervisor stated she then left the room to search for CNA #1. She did not find CNA #1 at the time and then got very busy with another resident and forgot about the situation. The next day she talked to the DON about the situation. They both then talked to the Resident #1 and CNA #1. CNA #1 admitted that she had set up Resident #1 for a partial bath and then left to go to dinner, but stated that was their routine. She denied telling the resident he/she was the reason other staff were quitting. CNA #1 was then sent home and after an investigation she was terminated. When asked how residents were protected from further abuse the rest of the night the alleged abuse occurred, the Supervisor	F 226	residents and for non-interviewable residents a family member will be interviewed to determine if any resident or family have experienced and/or observed any type of abuse or neglect that they have not reported. These interviews will begin on March 19, 2013 and will be completed by March 26, 2013. On March 19, 2013 the facility initiated staff interviews to determine if any employee had observed any type of resident abuse or neglect that they did not report. These interviews will be conducted by DON, and Director of Staff Development. Interviews will be completed by March 26, 2013. 3.A mandatory in-service on the Abuse Policy was presented by DON, ADON, Nurse Mangers and Director of Staff Development beginning 3-1-13 and completed on 3-13-13.		



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F 226	Continued From page 6 replied that CNA #2 helped Resident #1 return to bed. She said had she known of the alleged verbal abuse the night before she would have sent CNA #1 home. The Supervisor stated she dropped the ball because she got busy with another resident the night before and never talked to CNA #1. Interview with CNA #1, on 03/05/13 at 4:15 PM, revealed on 02/25/13 she was taking care of Resident #1. It was late and Resident #1 was getting ready for bed. She stated she unfastened Resident #1's blouse and released her brief and told the resident she would be back. She stated it normally took about thirty minutes for Resident #1 to wash up so she went for her dinner break. When she came back from dinner, CNA #2 told her Resident #1 was upset at being left undressed and her feelings were hurt by something she had said to him/her. Nothing more was said to her that night by anyone else. CNA #1 finished that shift and then worked another shift. She was orienting another CNA the next day when she was called to the DON's office. The DON told her she had been accused of verbal abuse by Resident #1. CNA #1 denied the allegation and was allowed to return to work. CNA #1 stated she cared about Resident #1 and treated her like her granny. About thirty minutes after that the DON called her back to the office and subsequently was sent home without explanation. CNA #1 stated she was confused because she thought if someone accused you of abuse that you were sent home right away and she had worked a double shift and was then allowed to start her next shift and was even orienting a new CNA. She denied abuse of any kind toward Resident #1.	F 226	In-service included review of Abuse Policy and Procedure including identification of abuse or neglect, types of abuse and neglect, investigation of abuse or neglect, including conducting staff interviews, the initial report, the 5 day report and need to arrive at a conclusion, also discussed protection of residents during the investigation.. To evaluate staff understanding a post test was given and was reviewed by the Director of Staff Development. . In-service for staff on Abuse Policy and Procedure will be repeated monthly for 3 months then no less than annually. All newly hired employees will be educated on the Abuse Policy during orientation. This will be the responsibility of the Director of Staff Development.		



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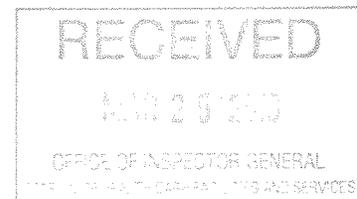
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F 226	<p>Continued From page 7</p> <p>Interview with Director of Nursing (DON), on 03/05/13 at 4:55 PM, revealed at around 4:00 PM on 02/25/13 she received a call from the daughter of Resident #1. The daughter requested CNA #1 not care for her mother anymore due to being rude to her mother. After the phone call the DON spoke with the Supervisor who reported to her the incidents of the night before. She and the Supervisor then interviewed CNA #1, who denied all allegations of abuse. CNA #1 then returned to work. Afterward the DON and Supervisor were talking and decided an investigation needed to be initiated. CNA #1 was asked to clock out and go home. The DON stated the system failed. Per facility policy the Supervisor should have notified the DON and Administrator when the incident was initially reported and CNA #1 should have been sent home immediately pending the outcome of the investigation. The DON revealed Resident #1 and the rest of the residents at the facility were not protected from further abuse/neglect because CNA #1 was not sent home when the allegation was made.</p>	F 226	<p>4. All reports of Abuse will be reviewed by the Administrator monthly to ensure appropriate investigation and if indicated reporting is completed. Director of Social Services to interview each resident or if resident not interviewable, a family member or responsible party quarterly for 2 quarters on if they have observed or experienced any form of abuse or neglect that they have not reported. Director of Social Services to review the facility Policy on Abuse in the monthly Resident Council meeting scheduled for March 28, 2013 and request feedback regarding any concerns related to abuse or neglect. Any concerns voiced will be immediately investigated and if appropriate reported to the appropriate agencies. Results of all audits and interviews will be reported to the facility QA Committee no less than quarterly for one year.</p> <p>Date of completion 3-29-13</p>	
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Office of Inspector General

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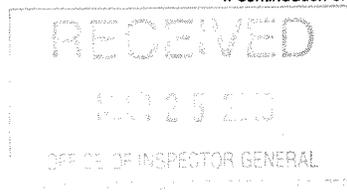
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N 000	INITIAL COMMENTS A complaint investigation for KY19871 was initiated and concluded on 03/05/13. The Division of Health Care substantiated the allegation with deficiencies cited.	N 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."	
N 105	902 KAR 20:300-5(3) Section 5. Resident Behavior & Fac. Practice (3) Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents. This requirement is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to protect residents of the facility from abuse for one (1) of three (3) sampled residents. A facility staff person, CNA #1, was accused of verbal abuse and neglect by Resident #1 and the facility failed to follow their policy on abuse. The supervisory staff allowed CNA #1 to continue to work with residents after an allegation of abuse had been made against her by Resident #1. The findings include: Review of the facility's policy regarding Abuse Prohibition, not dated, revealed residents had the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Any individuals suspected of causing abuse was to be removed from direct patient care and reassigned to non-patient care duties or suspended from duty until an investigation was completed and an administrative decision was made by the Administrator or governing body.	N 105	N 105 1. Resident #1 was assisted with her personal care needs by CNA#2 and CNA #1 did not care for Resident #1 after the reported incident on 2-25-13. CNA#1 was removed from duty on 2-26-13 and has not returned to work. 2. Acting Administrator reviewed all reports of abuse completed over the previous 6 months to ensure appropriate interventions were taken by staff. This was completed on March 7, 2013. On 2-27-13 facility initiated interviews with interviewable residents assigned to CNA#1 to ensure no other resident had been affected by employee's behavior. Social Services and ADON to interview all interviewable	

X L. Dennis Cantrell
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

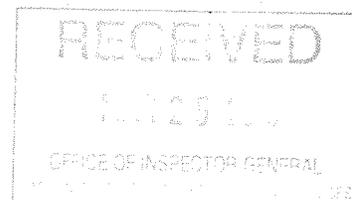
X Acting Administrator
TITLE

(X6) DATE
3-25-13



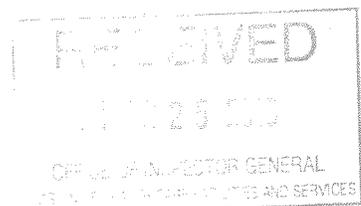
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NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
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N 105	Continued From page 1 Review of the clinical record for Resident #1 revealed the facility admitted the resident on 10/04/12 with diagnoses of Vascular Dementia, Chronic Kidney Disease, Diabetes, Hypertension, Neurogenic Bladder, Depression, Osteoarthritis and Esophageal Reflux. The facility completed a Resident Assessment Instrument on 01/11/13 and scored a Brief Interview of Mental Status at 11, which indicated the resident was moderately impaired. Interview with Resident #1, on 03/05/13 at 10:35 AM, revealed he/she requested help getting undressed from CNA #1. When CNA #1 was helping him/her get undressed, she told the resident he/she was the reason staff were quitting. Resident #1 stated his/her feelings were hurt because prior to that time Resident #1 felt there was a good rapport between the two of them. Resident #1 had even sent a Valentine card to CNA #1, complimenting the care she provided to the residents. Resident #1 also reported CNA #1 helped set her up for a partial bath by unfastening his/her blouse and brief. CNA #1 then left Resident #1 to start washing up for bed and then CNA #1 took her dinner break. Resident #1 stated CNA #1 never came back. About fifteen to thirty minutes later CNA #2 came in the room. After the resident explained what happened CNA #2 left to get her supervisor. Once the Supervisor saw how Resident #1 had been left, she instructed CNA #2 to finish getting him/her dressed and put to bed. Resident #1 stated his/her blouse was opened and the brief was wet and hanging down in front of the wheelchair. Resident #1 stated the supervisor asked all kinds of questions about why he/she had been left partially exposed. Resident #1 reported CNA #1 had not been back in her room.	N 105	residents and for non-interviewable residents a family member will be interviewed to determine if any resident or family have experienced and/or observed any type of abuse or neglect that they have not reported. These interviews will begin on March 19, 2013 and will be completed by March 26, 2013. On March 19, 2013 the facility initiated staff interviews to determine if any employee had observed any type of resident abuse or neglect that they did not report. These interviews will be conducted by DON, and Director of Staff Development. Interviews will be completed by March 26, 2013. 3.A mandatory in-service on the Abuse Policy was presented by DON, ADON, Nurse Managers and Director of Staff Development beginning 3-1-13 and completed on 3-13-13.	



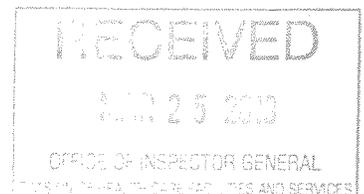
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N 105	Continued From page 2 Interview with CNA #2, on 03/05/13 at 3:09 PM, revealed on 02/25/13 about 8:30 PM she entered the room of Resident #1. She stated Resident #1's top was unzipped and she was exposed and the brief was open and hanging down in front of the wheelchair. Resident #1 told CNA #2 that CNA #1 had started his/her bath, but then left for her dinner break. Resident #1 told CNA #2 that was a long time ago. CNA #2 left and brought back the supervisor so she could see the condition Resident #1 had been left in. Once the supervisor saw the resident, CNA #2 changed Resident #1 and helped him/her to bed. CNA #2 stated CNA #1 came back from her dinner break and finished her shift. Interview with the Supervisor, on 03/05/13 at 3:25 PM, revealed CNA #2 reported to her that Resident #1 was upset and had been left in a mess. She went to the resident's room and found Resident #1 with his/her top open and breasts partially exposed and the brief was opened, flapped down in front of the wheelchair and it looked like it was wet. The Supervisor instructed CNA #2 to assist Resident #1 get cleaned up and put to bed. The Supervisor stated she then left the room to search for CNA #1. She did not find CNA #1 at the time and then got very busy with another resident and forgot about the situation. The next day she talked to the DON about the situation. They both then talked to the Resident #1 and CNA #1. CNA #1 admitted that she had set up Resident #1 for a partial bath and then left to go to dinner, but stated that was their routine. She denied telling the resident he/she was the reason other staff were quitting. CNA #1 was then sent home and after an investigation she was terminated. When asked how residents were protected from further abuse the rest of the night the alleged abuse occurred, the Supervisor	N 105	In-service included review of Abuse Policy and Procedure including identification of abuse or neglect, types of abuse and neglect, investigation of abuse or neglect, including conducting staff interviews, the initial report, the 5 day report and need to arrive at a conclusion, also discussed protection of residents during the investigation.. To evaluate staff understanding a post test was given and was reviewed by the Director of Staff Development. . In-service for staff on Abuse Policy and Procedure will be repeated monthly for 3 months then no less than annually. All newly hired employees will be educated on the Abuse Policy during orientation. This will be the responsibility of the Director of Staff Development.	



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N 105	Continued From page 3 replied that CNA #2 helped Resident #1 return to bed. She said had she known of the alleged verbal abuse the night before she would have sent CNA #1 home. The Supervisor stated she dropped the ball because she got busy with another resident the night before and never talked to CNA #1. Interview with CNA #1, on 03/05/13 at 4:15 PM, revealed on 02/25/13 she was taking care of Resident #1. It was late and Resident #1 was getting ready for bed. She stated she unfastened Resident #1's blouse and released her brief and told the resident she would be back. She stated it normally took about thirty minutes for Resident #1 to wash up so she went for her dinner break. When she came back from dinner, CNA #2 told her Resident #1 was upset at being left undressed and her feelings were hurt by something she had said to him/her. Nothing more was said to her that night by anyone else. CNA #1 finished that shift and then worked another shift. She was orienting another CNA the next day when she was called to the DON's office. The DON told her she had been accused of verbal abuse by Resident #1. CNA #1 denied the allegation and was allowed to return to work. CNA #1 stated she cared about Resident #1 and treated her like her granny. About thirty minutes after that the DON called her back to the office and subsequently was sent home without explanation. CNA #1 stated she was confused because she thought if someone accused you of abuse that you were sent home right away and she had worked a double shift and was even orienting a new CNA. She denied abuse of any kind toward Resident #1.	N 105	4. All reports of Abuse will be reviewed by the Administrator monthly to ensure appropriate investigation and if indicated reporting is completed. Director of Social Services to interview each resident or if resident not interviewable, a family member or responsible party quarterly for 2 quarters on if they have observed or experienced any form of abuse or neglect that they have not reported. Director of Social Services to review the facility Policy on Abuse in the monthly Resident Council meeting scheduled for March 28, 2013 and request feedback regarding any concerns related to abuse or neglect. Any concerns voiced will be immediately investigated and if appropriate reported to the appropriate agencies. Results of all audits and interviews will be reported to the facility QA Committee no less than quarterly for one year.	



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N 105	Continued From page 4 Interview with the Director of Nursing (DON), on 03/05/13 at 4:55 PM, revealed at around 4:00 PM on 02/25/13 she received a call from the daughter of Resident #1. The daughter requested CNA #1 not care for her mother anymore due to being rude to her mother. After the phone call the DON spoke with the Supervisor who reported to her the incidents of the night before. She and the Supervisor then interviewed CNA #1, who denied all allegations of abuse. CNA #1 then returned to work. Afterward the DON and Supervisor were talking and decided an investigation needed to be initiated. CNA #1 was asked to clock out and go home. The DON stated the system failed. Per facility policy the Supervisor should have notified the DON and Administrator when the incident was initially reported and CNA #1 should have been sent home immediately pending the outcome of the investigation. The DON revealed Resident #1 and the rest of the residents at the facility were not protected from further abuse/neglect because CNA #1 was not sent home when the allegation was made.	N 105			

