

*Acceptable*  
4/26/13 No. 3300 P. 13

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

PRINTED: 06/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Abbreviated/Partial Extended Survey to investigate KY00020042 was initiated on 04/12/13 and concluded on 04/24/13. In addition, an investigation of KY00020098 was initiated on 04/22/13 and concluded on 04/24/13 and was determined to be unsubstantiated. KY00020042 was substantiated with deficiencies identified. Substandard Quality of Care (SQC) was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. Immediate Jeopardy (IJ) was identified on 04/15/13, and was determined to exist on 01/25/13 with deficiencies cited at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225, and F-226 and 42 CFR 483.75 Administration, F-490 at a Scope and Severity (S/S) of a "J". The facility was notified of the Immediate Jeopardy on 04/15/13. In addition, a deficiency was identified at 42 CFR 483.20 Resident Assessment, F-273 at a S/S of a "D".</p> <p>The facility failed to ensure all residents were free of abuse. On 01/25/13, the facility received an allegation of abuse from Resident #2, who reported State Registered Nurse Aide (SRNA) #1 got in his/her bed and straddled him/her. Two (2) Social Workers (SW) interviewed Resident #2 and gave written accounts of their conversations with the resident. During interview, and upon review of the written statements, SW #1 reported the resident stated SRNA #1 did not get in his/her bed, but "he wanted to and I told him to get the hell out of here". SW #2 reported Resident #2, in reference to SRNA #1, stated "he thinks he's sexy and tried to get in bed with me, but I kicked him away". SW #1 documented Resident #2 was</p>	F 000	<p><b>RECEIVED</b> JUN - 4 2013</p> <p>BY: _____</p> <p>Plan of Correction Cambridge Place Abbreviated Standard/Partial Extended Survey 4/24/2013</p> <p>DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES WITH AND DISPUTES THE DEFICIENCIES STATED IN THE 2567 AND THE SCOPE AND SEVERITY AT WHICH THEY ARE CITED. FURTHER, THE FACILITY DISPUTES AND DISAGREES WITH THE ACCURACY OF STATEMENTS AND OTHER INFORMATION RELIED UPON IN THE 2567 IN SUPPORT OF THE ALLEGED DEFICIENCIES. THIS INCLUDES, BUT IS NOT LIMITED TO, THE ALLEGED CONTENT/SUMMARY OF INTERVIEWS, THE CHRONOLOGICAL/TIMING SEQUENCE OF EVENTS AND CONTACT WITH HEALTH CARE PROFESSIONALS, AND THE DESCRIPTION OF THE CARE AND SUPERVISION PROVIDED TO THE RESIDENTS. THE FACILITY RESERVES ITS RIGHT TO CONTINUE DISPUTING, APPEALING AND CONTESTING THESE DEFICIENCIES AND ANY ACTION RELATED TO OR ARISING THEREFROM IN ANY OTHER FORUM AS NEEDED.</p>		

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

*Colleen Johnson*

TITLE

(X6) DATE

6/4/13

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.

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185444</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/24/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>Continued From page 1</p> <p>being treated for a Urinary Tract Infection, and was having increased confusion and hallucinations. Further record review revealed there was no documented evidence an investigation of the incident was conducted. The facility failed to investigate the allegation per their policy, and failed to report the allegation to the appropriate parties, including the State Agency. Interviews with Administrative Staff revealed they determined, based on the resident's confusion and SRNA #1's adamant denial of the incident, there was not a credible allegation to be thoroughly investigated or reported. SRNA #1 was allowed to continue working in an unrestricted manner.</p> <p>On 04/12/13 at approximately 2:45 AM, per interview and record review Registered Nurse (RN) #1 entered the room of Resident #1. She observed Resident #1 to be lying sideways on the bed, and SRNA #1 standing between Resident #1's open legs. During interview, RN #1 revealed SRNA #1 immediately began adjusting his pants and moved away from Resident #1. RN #1 stated she turned on the light and noted SRNA #1 had an erection which was clearly visible through his pants, and his belt was open with the ends of the belt hanging down on either side. Interview with the investigating detective revealed SRNA #1 was arrested and charged under the Elder Justice Act, which prohibits abuse, and a criminal investigation was ongoing.</p> <p>The facility submitted an acceptable Allegation of Compliance (AOC), related to the Immediate Jeopardy, on 04/23/13, with the facility alleging removal of the Immediate Jeopardy on 04/18/13. On 04/24/13, the State Survey Agency verified the</p>	F 000			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 2 Immediate Jeopardy was removed on 04/18/13 as alleged, with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-225, and F226; and 42 CFR 483.75 Administration, F-490 at a S/S of an "D" while the facility developed and implemented the facility's Plan of Correction and the facility's Quality Assurance Program continued to monitor and ensure residents were protected from abuse. Additionally, the facility remained non-compliant at 42 CFR 483.20 Resident Assessment, F-273 at a S/S of a "D".	F 000			
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure each resident was free from sexual abuse for two (2) of five (5) sampled residents (Resident #1 and Resident #2).  On 01/25/13, the facility received an allegation of abuse from Resident #2, who reported State Registered Nurse Aide (SRNA) #1 got in his/her	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 3</p> <p>bed and straddled him/her. Two (2) Social Workers (SW) interviewed Resident #2 and gave written accounts of their conversations with the resident. During interview with SW #1, and upon review of the written statements, it was revealed both SWs reported Resident #2 referred to a leaking water heater over his/her head that needed to be fixed immediately, as evidence Resident #2 had hallucinations. Interviews with Administrative Staff revealed they determined, based on the SW interviews, the resident's confusion and changing of the story, and SRNA #1's adamant denial of the incident, there was not a credible allegation of abuse to be thoroughly investigated or reported. SRNA #1 was allowed to continue working in an unrestricted manner. No further documented evidence related to an investigation was provided.</p> <p>On 04/12/13, at approximately 2:45 AM, Registered Nurse (RN) #1 entered the room of Resident #1. She observed Resident #1 to be lying sideways on the bed, and SRNA #1 was standing between Resident #1's open legs. During interview, RN #1 revealed SRNA #1 immediately began adjusting his pants and moved away from Resident #1. RN #1 stated she turned on the light and noted SRNA #1 had an erection which was clearly visible through his pants, and his belt was open with the ends of the belt hanging down on both sides. Interview with the investigating detective revealed SRNA #1 was arrested and charged under the Elder Justice Act, which prohibits abuse, and a criminal investigation was ongoing.</p> <p>Based on the findings, the facility's failure to protect residents for abuse has caused or is likely</p>	F 223	<p><b>F 223 Abuse</b> The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>Criterion 1: -The local police department, Department for Community Based Services, and Office of Inspector General were all notified of the allegation on 4-12-13. The facility immediately initiated investigations on 4-12-13 at 2:45 a.m.; the local police arrived shortly thereafter and began investigating as well. The Medical Director was contacted at 3:15 a.m. -Residents # 1 and 2 were sent to the hospital for evaluation and assessment on 4/12/13. Both returned to the facility on the same day and were offered/received follow-up counseling by the psychiatric consultant services and/or the Rape Crisis Center. -The identified staff member was removed immediately and sent a certified letter terminating his employment on 4-13-13.</p> <p>Criterion 2: -All residents were interviewed by the Medical Director to determine if they had experienced any potential negative effects related to this allegation. All residents, except 6 who refused, have been physically examined by the Medical Director, with documentation of all interview and assessment findings. The interviews/exams were performed by the Medical Director on 4/12/13, 4/13/12, 4/14/12 and completed on 4/15/13. No</p>		

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 4</p> <p>to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 04/15/13 and was determined to exist on 01/25/13. The facility was notified of the Immediate Jeopardy on 04/15/13.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) on 04/23/13, with the facility alleging the IJ had been removed on 04/18/13. On 04/24/13, the State Survey Agency verified the IJ was removed on 04/18/13 as alleged, with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223 at a Scope and Severity (S/S) of a "D" while the facility develops and implements its Plan of Correction and the facility's Quality Assurance Program continues to monitor and ensure residents are protected from abuse.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Policy on Abuse", undated, revealed sexual abuse was defined as, but not limited to, sexual harassment, sexual coercion or sexual assault. Continued review revealed the facility would actively promote the absence of abuse from all individuals.</p> <p>1. Review of the clinical record revealed the facility admitted Resident #2 on 05/31/04 with diagnoses which included Generalized Muscle Weakness, Debility, Depression and Senile Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment, completed by the facility on 12/28/12, revealed Resident #2 scored ten (10) of a possible fifteen (15) in cognition, indicating the resident was moderately impaired</p>	F 223	<p>residents exhibited emotional, verbal or physical indications of harm.</p> <p>-All residents have had completion of the PHQ9 interview, or the PHQ9-OV staff assessment for mood/anxiety, as completed by the Social Services staff on 4-12-13, to identify any who may be experiencing distress/anxiety related to the reported allegation. Residents were also asked questions during these interviews/assessments to determine if they had any concerns regarding their care or caregivers, if they felt safe in the facility, or if they had any concerns related to abuse. No residents had a score on the PHQ9 or PHQ9-OV that indicated any mood or anxiety issues. The PHQ9 interview and/or PHQ9-OV assessment and interview questions pertaining to care/caregivers and any concerns related to abuse, will be redone again in 1 week, and in 2 weeks by the Social Service staff to determine that there are no delayed effects experienced by the residents.</p> <p>-The families/responsible parties for all residents were contacted and informed of the allegation on 4-12-13, 4-15-13 and 4-16-13 by the Social Service staff, the DON and the ADON. Certified letters were sent on 4-17-13 to any families who could not be reached by telephone.</p> <p>-The facility increased security on the night shift with facility staff on 4-12-13 and a security officer service was employed by the facility for the night shift on 4-13-13.</p> <p><b>Criterion 3:</b></p> <p>-All facility staff were inserviced on abuse and the facility abuse policy, including, but not limited to: identification, protection of residents, and reporting of abuse, as provided by the Staff Development Coordinator on 4/12/13 - 4/16/13. Any</p>		

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 5</p> <p>In cognitive skills. Review of Section D of the Quarterly MDS Assessment related to Mood revealed Resident #2 had trouble concentrating on things, but was assessed with no other indicators for mood disturbance. Review of Section E0100 revealed Resident #2 exhibited no hallucinations and no delusions during the assessment period.</p> <p>Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed Resident #2 alleged, a few months ago (01/25/13), SRNA #1 had straddled him/her in the bed. She stated two Social Workers (SW) went immediately to interview the resident, who then denied the allegation. The Administrator stated Resident #2 had a history of confusion and seeing things that weren't there, and was being treated for a Urinary Tract Infection at the time of the allegation. She stated the facility declined to conduct a formal investigation.</p> <p>During interview, on 04/12/13 at 5:05 PM, Resident #2 stated "it was at least a couple of weeks ago" that SRNA #1 got in his/her bed and straddled him/her, with one leg on each side. The resident reported that he/she told SRNA #1, "you better get off me", and he did. Resident #2 further stated he/she reported the incident when it occurred, but could not say who he/she reported to, and did not recall anything about an investigation.</p> <p>Review of the written statement of SW #1, dated 01/25/13, revealed Resident #2 stated SRNA #1 did not get in his/her bed, but "he wanted to and I told him to get the hell out of here". Review of the written statement by SW #2, also dated 01/25/13,</p>	F 223	<p>staff on leave, vacation, or unavailable for the inservice has been locked out of the time clock, and will not be able to clock in or work until completing the inservice education.</p> <p>-All nurse supervisors and administrative nurses have received inservice education on the investigation and reporting of abuse as provided by the DON and ADDN on 4-16-13, including but not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses; and reporting of allegations and findings.</p> <p><b>Criterion 4:</b></p> <p>-All allegations will be reviewed by the facility investigation team (Administrator, Social Service Director, DON and ADDN) to determine which team members will investigate and report the allegation to the required authorities seven days per week.</p> <p>-The facility QA Committee, with the Medical Director, convened on 4-17-13 at 9:20 a.m. to review the circumstances of the allegation and all interventions which have been and will be implemented by the facility. The facility QA Committee met again on 5-23-13 with the Medical Director for the regularly scheduled QA Committee Meeting.</p> <p>-The Administrator shall complete an allegation checklist with each allegation investigation to determine that facility policy and procedure was accurately and thoroughly followed. The checklist details the required steps of the investigation process from beginning to end to step the investigator through all aspects. If the Administrator is unavailable, the DON or Social Services Director will complete the checklist. Any item on the checklist determined to be incomplete shall be corrected under the supervision of the Administrator and the appropriate team member re-educated.</p> <p>-The Administrator will complete an allegation checklist audit for 100% of the allegations made and investigated.</p> <p>-The CQI Indicator for the monitoring of compliance</p>		

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	<p>Continued From page 6</p> <p>revealed Resident #2, in reference to SRNA #1, stated "he thinks he's sexy and tried to get in bed with me, but I kicked him away". Both statements indicated Resident #2 exhibited hallucinations about a leaky water heater on the ceiling.</p> <p>Interview with SW #1, on 04/15/13 at 3:40 PM, revealed SW #2 was no longer employed at the facility. SW #1 stated Resident #2 denied SRNA #1 had gotten in his/her bed. She further stated she and SW #2 felt Resident #2 was confused and delusional. Therefore, they determined Resident #2 had not made a credible allegation.</p> <p>Interview with the Director of Nursing (DON) and the MDS Nurse, on 04/15/13 at 4:00 PM, revealed the MDS Nurse was House Supervisor (HS) at the time of Resident #2's allegation regarding SRNA #1. Continued interview revealed the DON and the HS had interviewed SRNA #1 on 01/25/13 after hearing of the allegation against him. The DON and the HS concurred SRNA #1 was very defensive and indignant during the interview, and adamantly denied any inappropriate comments or behaviors while providing care to Resident #2. They stated SRNA #1 seemed "very sincere". The DON and the HS both stated that based on the resident's confusion by history, no observations of anything inappropriate by [SRNA #1], his adamant denial, and the resident changing his/her story, they felt it was not a credible allegation.</p> <p>During follow-up interview, on 04/15/13 at 3:05 PM, the Administrator stated two (2) Social Workers interviewed Resident #2 at different times. During both interviews, the resident denied SRNA #1 had gotten in his/her bed, and</p>	F 223	<p>with the components of the abuse regulation including, but not limited to, investigating and reporting of abuse, will be utilized weekly X 4 weeks and then monthly thereafter under the supervision of the Administrator.</p> <p>-The findings of the completed allegation checklists and CQI indicators will be reviewed by the corporate contracted nurse consultant with monthly visits, to determine that allegations were investigated and reported as indicated.</p> <p>-In the event of an allegation checklist found to be incomplete and/or the CQI indicator fails to meet threshold, the Administrator, with guidance from the nurse consultant, will formulate a Plan of Action and present it to the QA committee for review and recommendations.</p> <p>-The Administrator developed a Plan of Correction checklist to assure ongoing completion of corrective action on a weekly basis. All corrective actions are included. The checklist will be completed monthly x 4. The Administrator will report the results to the QA Committee monthly.</p> <p>Criterion 5:</p>	4/26/13

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 7 exhibited hallucinations when he/she became upset about a water heater that was not there. Based on the resident's confusion and hallucination about the water heater, and the resident changed his/her story, the Administrator concluded the allegation had no merit, i.e. was not credible, and no further investigation was warranted.  However, review of the employee file for SRNA #1 revealed an employee conference was held on 01/25/13 and there was written counseling related to maintaining a professional approach with residents and treating all residents with respect during care giving. Further review revealed the DON documented SRNA #1 "denied inappropriate interactions with any residents and refused to sign".  Review of the staffing schedule for January 2013 revealed SRNA #1 was working the night shift on 01/25/13 on the East Hall where Resident #2 resided. Continued review revealed SRNA #1 worked the 11-7 shift on the East Hall nearly every night, including 01/01/13 through 01/10/13, and 01/15/13 through 01/31/13. Continued review of the staffing schedule revealed SRNA #1 continued working regularly, up to and including the night shift of 04/12/13.	F 223			
	2. On 04/12/13, the State Agency received a facility reported incident of "possible sexual assault" when an employee was observed in a "compromising position" with Resident #1.  Review of the clinical record revealed the facility admitted Resident #1 on 08/30/11 with diagnoses which included Generalized Muscle Weakness.				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 8</p> <p>Difficulty Walking, Depression and Insomnia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/04/13, revealed the facility's assessment of the resident included a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of a possible fifteen (15), indicating the resident was cognitively intact and therefore interviewable.</p> <p>Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed on 04/12/13 the House Supervisor (HS)/RN #1 working the night shift entered Resident #1's room and observed SRNA #1 with his belt unbuckled and an erection visible through his pants. She immediately sent SRNA #1 to the desk while she evaluated the situation to ensure Resident #1 was okay. Initially, the resident denied anything happened and denied any complaints. The HS/RN #1 left the room to find SRNA #1 and confirmed he had been seen going out of the facility, and a search of the parking lot revealed his car was gone. The HS/RN #1 went back to Resident #1's room with the Nurse assigned to his/her care Licensed Practical Nurse (LPN #2). At this time, the resident reported SRNA #1 was giving therapy "on my bottom". The resident further reported SRNA #1 gave him/her therapy about once a week. The Administrator was called at home, and she called 911 and came to the facility. The facility's investigation was initiated immediately and was ongoing.</p> <p>Review of the written statement provided by RN #1 after the incident, and interview with RN #1, on 04/17/13 at 9:15 AM, revealed she was working in the position of House Supervisor on the night shift of 04/12/13. During her routine rounds, at</p>	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 9 approximately 2:30 AM to 2:45 AM, she entered the room of Resident #1. The door was open, the curtain was pulled around the resident, and the light was off. The Nurse was not aware at that time anyone else was in the room. Without saying anything, she peeked around the curtain. Resident #1 was lying sideways with his/her bottom at the edge of the bed. His/her legs were bent at the hips and the knees, and the resident's knees were apart and up in the air. SRNA #1 was standing between Resident #1's legs in a crouching position, with his knees bent slightly and one hand on each of the resident's legs. As the Nurse pulled the curtain back, SRNA #1 looked up and saw the Nurse, stood up and began adjusting his pants. RN #1 was shocked and couldn't believe what she was seeing. She asked SRNA #1 if the resident was sliding out of the bed. SRNA #1 replied "yes" and began walking away. The Nurse turned the light on and observed SRNA #1 to have an erection clearly visible through his pants, and his belt was undone with the ends hanging down on either side. RN #1 instructed SRNA #1 to go to the desk. When he left the room, the Nurse began asking Resident #1 what happened. The resident was very calm, "emotionless", and reported nothing had happened. The resident had no complaints at that time. The Nurse went out to the Nurse's station where LPN #2 was sitting. She asked him where SRNA #1 was, and the LPN replied he walked past the desk in the direction of the exit door. A staff member (RN #1 could not remember who) went to the parking lot and verified SRNA #1's car was gone. RN #1 and LPN #2 went back to Resident #1's room to ensure the resident was okay, and try to determine what exactly had happened. On	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 10</p> <p>examination, the resident's perineal area appeared red and moist, but no lacerations, bruising or bleeding was noted. At this time, the resident stated he/she was "getting therapy in my bottom". The resident reported SRNA #1 provided the therapy "at least once a week". The resident also pointed to the left lower quadrant of his/her abdomen and stated it hurt. When RN #1 had ensured Resident #1 was not in acute physical or mental distress, she called the Director of Nursing (DON) at home and reported the incident. Ultimately, the Administrative team, the facility's Medical Director, local police, and Emergency Medical Services (EMS) responded to the facility. Resident #1 was transported to the Emergency Department (ED) at a local hospital for examination.</p> <p>Interview with LPN #2, on 04/16/13 at 3:47 PM, revealed he was the Nurse assigned to Resident #1 on the night shift of 04/12/13. He stated he was at the desk between 2:30 AM and 2:50 AM when SRNA #1 walked by, in the direction of the exit on the other side of the building. He stated he assumed SRNA #1 was going outside to smoke. He further stated within two (2) minutes, RN #1 approached the desk and stated SRNA #1 had to go home and reported she had observed him in a sexually inappropriate encounter with Resident #1. Continued interview revealed he went outside and saw SRNA #1's car was gone from the parking lot. On further interview, LPN #2 stated he went to check on Resident #1 with RN #1. He stated the resident pointed to the left lower quadrant of the abdomen and complained of pain. LPN #2 further reported Resident #1 stated SRNA #1 was giving him/her therapy and stated it had happened before, "about once a</p>	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 11 week".</p> <p>Review of the ED record for Resident #1 revealed the resident arrived on 04/12/13 at 4:35 AM, and was the reported victim of a sexual assault at the nursing home where he/she resided. Further review revealed the Sexual Assault Nurse Examiner (SANE) was in route to perform the physical examination. Continued review revealed all results of the examination, including any specimens collected, were turned over to law enforcement officials. Resident #1 was medically cleared and discharged back to the nursing home for follow up care.</p> <p>Observation, on 04/12/13 at 4:50 PM, revealed Resident #1 had been moved to a different room, as his/her previous room was considered a crime scene and a police investigation was ongoing. Resident #1 was sitting on the side of the bed and appeared clean and well-groomed, and was dressed appropriately in personal attire. The resident demonstrated a very flat affect, i.e. he/she exhibited no change in facial expression or tone of voice.</p> <p>During interview, on 04/12/13 at 4:50 PM, Resident #1 stated "I was raped last night". Resident #1 stated there was one other incident "a long time ago", he/she did not report the first incident and couldn't figure out how everybody found out this time. Resident #1 referred to SRNA #1 by name and stated, "he hurt me up inside". On further interview, Resident #1 expressed ambivalent feelings toward SRNA #1, e.g. "he was very kind", and "I was afraid of him". Resident #1 denied a clear memory of the day's events but stated it had been a very long day and</p>	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 12 he/she was very tired and "done talking about it".  Interview with the sister of Resident #1, on 04/14/13 at 11:36 AM, revealed she was the resident's Power of Attorney (POA). She stated the facility called her about 3:00 AM on 04/12/13 and reported Resident #1 was the victim of a possible sexual assault. She further stated she and the resident's daughter went directly to the hospital Emergency Department and met Resident #1 there. On further interview, the POA stated the Sexual Assault Nurse Examiner (SANE) told her she examined the resident for evidence of sexual assault and found him/her to have a small tear and some blood. During continued interview, the POA stated she knew Resident #1 was swabbed "for semen and stuff" but the results weren't back yet.  Interview with SRNA #3, on 04/18/13 at 10:40 AM, revealed she accompanied Resident #1 in the ambulance to the ED. She stated she remained with the resident throughout the stay and return trip to the facility. She further stated the resident did not speak of the incident in the ambulance; however, when the family arrived at the ED, Resident #1 told them SRNA #1 had raped him/her. Continued interview revealed SRNA #3 was present during the examination by the SANE Nurse. She stated she helped hold the resident's legs during the exam, and reported the resident appeared to be "ripped a little on the inside".  Interview with the lead detective for the criminal investigation, on 04/15/13 at 1:40 PM, revealed he was in charge of the investigation and was still collecting information. During interview on	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 13</p> <p>04/18/13 at 3:40 PM, the detective revealed SRNA #1 had been arrested under the Elder Justice Act, which prohibits abuse. He stated the investigation was ongoing; however, it would be several months before results of the forensic evidence analysis would be available.</p> <p>Interview with Physician #3, from the facility's contracted Psychiatric Services, on 04/16/13 at 3:20 PM, revealed he had evaluated Resident #1 earlier that day on 04/16/13. He stated the resident readily reported having been raped by SRNA #1. The resident stated it had happened twice. Physician #3 further stated Resident #1 exhibited a flat affect and increased sadness. He explained the resident was experiencing mixed emotions. Despite the rape, the resident was dealing with the loss of a friend, as SRNA #1 was kind and made him/her feel special.</p> <p>Follow-up interview with Resident #1, on 04/23/13 at 3:00 PM, revealed the resident had been "awful nervous", but no longer felt afraid and was glad SRNA #1 had been arrested. He/she stated SRNA #1 raped him/her twice, the first time was a long time ago. On further interview, Resident #1 stated SRNA #1 said he was giving therapy. The resident could not say what kind of therapy, "just therapy". The resident further stated "he shouldn't have done it".</p>	F 223			
	<p>Interview with the Medical Director, on 04/16/13 at 3:10 PM, revealed he had been fully involved in the facility's response to the incident with Resident #1 on 04/12/13. Continued interview revealed he approached each resident and asked if they had any concerns with any staff acting inappropriately. He stated while talking to</p>				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 14</p> <p>Resident #2 the resident reported someone, an employee, straddled him/her some time ago. The resident gave no other details except to say he/she told the perpetrator, "get off you SOB". The Physician declined to perform a physical exam, but reported the interview to the police and sent Resident #2 to the Emergency Department as well, in case there was any physical evidence to be obtained. On further interview, the Medical Director stated on thinking back, he recalled Resident #2 had made an allegation of some sort, but he had not interviewed him/her at that time. He stated he knew the facility did some sort of investigation and he recalled the facility felt Resident #2 was confused when the allegation was made, talked about a radiator, and was being treated for a Urinary Tract Infection. He stated perhaps if the State Survey Agency had been involved, it would have made a difference, but asked "how could you have known any different if he/she changed her story?"</p> <p>Review of the facility's investigation summary, dated 04/16/13, revealed abuse was substantiated. The facility determined SRNA #1 was the perpetrator of sexual abuse and was terminated.</p> <p>The facility provided an acceptable AOC on 04/23/13 with an alleged removal of the IJ on 04/18/13. Review of the AOC by the State Survey Agency revealed the facility implemented the following actions:</p> <p>1. The facility immediately initiated an investigation on 04/12/13 at 2:45 AM. The Police Department (PD), the Department for Community Based Services (DCBS), the Office of the</p>	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 15 Inspector General (OIG, referred to as State Agency), and the Medical Director were notified.  2. Residents #1 and #2 were sent to the hospital for evaluation on 04/12/13. Both residents returned to the facility the same day and were offered follow-up counseling by the consultant Psychiatric Services and/or the Rape Crisis Center.  3. The identified staff member was removed immediately and sent a certified letter terminating his employment on 04/13/13.  4. All residents were interviewed by the Medical Director to determine if they had experienced any potential negative effects related to the allegation. All residents, except six (6) who refused, were physically examined by the Medical Director, beginning 04/12/13 and completed on 04/15/13.  5. The Social Services staff completed the PHQ9 interview, or the PHQ9-OV Assessment for mood/anxiety on 04/12/13. No resident had a score on the PHQ9 interview or the PHQ9-OV Assessment that indicated any mood or anxiety concerns. The facility was to repeat the interviews/assessments in one week and in two weeks, to evaluate for any delayed effects experienced by the residents.	F 223			
	6. The families and/or responsible parties for all residents were contacted and informed of the allegation. The Social Services staff, the Director of Nursing, and the Assistant Director of Nursing phoned each party beginning on 04/12/13. Any family and/or responsible party that could not be reached by phone by 04/16/13 was sent a				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 16 certified letter on 04/17/13.  7. The facility employed a security officer for the night shift, beginning 04/13/13 and ongoing. In addition, increased staff on the night shift for added security, beginning 04/12/13.  8. All facility staff was inservice on abuse and the facility's abuse policy, including, but not limited to: identification, protection of residents, and reporting of abuse, as provided by the Staff Development Coordinator on 04/12/13 through 04/16/13. Any staff on leave, vacation, or unavailable for the inservice was locked out of the time clock, and will not be able to clock in or work until completing the inservice education.  9. All Nurse supervisors and administrative Nurses received inservice education on the investigation and reporting of abuse as provided by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 04/16/13, including but not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses; and reporting of allegations and findings.  10. All allegations are to be reviewed seven (7) days per week by the facility's investigation team, consisting of the Administrator, the Social Service Director, the DON and the ADON, to determine which team members will investigate and report the allegation to the required authorities.  11. The facility's Quality Assurance Committee, with the Medical Director, met on 04/17/13 to review the circumstances of the allegation and all interventions which had been or would be	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 17 implemented by the facility.</p> <p>12. The CQI indicator for the monitoring of compliance with the components of the abuse regulation, including, but not limited to, investigating and reporting of abuse, are to be utilized with each allegation. The CQI indicator is to be used at least weekly for four (4) weeks, then monthly under the supervision of the Administrator.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed she had called 911 immediately after receiving the report of the incident. She stated the PD responded immediately. Interview with the Lead Detective, on 04/15/13 at 1:40 PM, revealed he had assumed charge of the investigation on the morning of 04/12/13, from the night shift officer who responded to the 911 call.</p> <p>2. A review of hospital records revealed Resident #1 and Resident #2 were evaluated in the ED and transferred back to the facility on 04/12/13. Interview with Resident #2, on 04/23/13 at 2:50 PM revealed a lot of people had been talking to her, but she did not remember who. Interview with Resident #1, on 04/23/13 at 3:00 PM, revealed she had talked to the Rape Crisis Counselor. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed she had spoken with the Rape Crisis Counselor in the facility on 04/15/13 and 04/16/13. She stated the counselor had a private interview with Resident #1 on 04/16/13 and would return weekly as needed.</p>	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 18</p> <p>She further stated Resident #2 refused the service. Interview with the contracted Psychiatric Services physician, on 04/16/13 at 3:20 PM, revealed he had seen and evaluated Resident #1 and Resident #2 on that day.</p> <p>3. Interviews with LPN #2 on 04/16/13 at 3:45 PM, RN #1 on 04/17/13 at 9:15 AM, and RN #2 on 04/21/13 at 8:30 PM revealed SRNA #1 left the facility immediately after the incident and had not returned. RN #2 observed SRNA #1 leave via the side exit. LPN #2 went into the parking lot and confirmed SRNA #1's car was gone. Review of the letter addressed to SRNA #1, dated 04/12/13, revealed the following: "Effective immediately, you are no longer an employee of (this facility). You are not to come to this facility for any reason. Your pay check will be mailed to you." The letter was signed by the Administrator. A review of the Certified Letter ticket confirmed the letter was sent as alleged.</p> <p>4. Review of the Physician's notes revealed he interviewed all one hundred and one (101) residents in the facility between 04/12/13 and 04/15/13. A physical examination was performed on ninety-five (95) residents, six (6) residents refused the examination, but did participate in the interview. Continued review revealed only Resident #1 and Resident #2 had identified concerns. All other residents denied any inappropriate sexual behavior or abuse. All physical exams were normal; specifically, there was no bleeding, bruising, discharge or excoriation. During Interview on 04/16/13 at 3:10 PM, the Physician confirmed the resident interviews and examinations were completed.</p>	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 19</p> <p>5. Review of the MDS Section D for Mood (PHQ-9) revealed every resident was assessed on 04/12/13 and again one week later, on 04/19/13. Continued review revealed no immediate or delayed reactions to the incident were identified. The assessments included standardized questions related to mood and open-ended questions to identify any specific problems or anxiety. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the assessments would be performed again at the two (2) week mark, on 04/26/13.</p> <p>6. Interview with SW #1, on 04/15/13 at 3:40 PM, revealed she was in the process of contacting the families/responsible parties of all resident regarding the incident on 04/12/13. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed only five (5) families had not been contacted by 04/16/13. Certified letters were sent to these families on 04/17/13, confirmed by review of the postal tickets. Review of the letter, dated 04/17/13 and signed by the Administrator revealed the families were being contacted by letter as the facility had been unable to reach them by phone. Continued review revealed the addressees were informed of an alleged sexual assault at the facility and measures were being taken to ensure all residents were protected. Contact information for any questions or concerns was included.</p>	F 223			
	<p>7. Interview with LPN #2, on 04/16/13 at 3:47 PM, SRNA #2 on 04/18/13 at 10:24 AM, SRNA #4 on 04/18/13 at 10:56 AM, and RN #2 on 04/21/13 at 8:30 AM, revealed a security guard was present on the night shift since the incident. In addition, extra staff was on duty at night for added</p>				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 20 security. Continued interview revealed the security guard and staff patrolled the building and the grounds throughout the night, ensured doors and windows were secure, and checked with staff for any problems. Interview with the Administrator, on 04/24/13 at 9:40 am revealed the security guard had been hired through a local security service and was on duty 10:00 PM until 6:00 AM. In addition, an extra staff person, e.g. Maintenance, Housekeeping, or SRNA was on duty on the night shift, from 11:00 PM until 7:00 AM. She stated male staff who exhibited a strong presence were chosen for the extra shifts at night.  8. Interviews with LPN #1, on 04/15/13 at 2:15 PM, LPN #2 on 04/16/13 at 3:47 PM, RN #1 on 04/17/13 at 9:15 AM, SRNA #2 on 04/18/13 at 10:24 AM, SRNA #6 on 04/23/13 at 1:32 PM, East Wing Unit Coordinator on 04/18/13 at 2:15 PM, and SRNA #5 on 04/23/13 at 3:50 PM, revealed all had attended mandatory inservices since the incident of 04/12/13. The training included appropriate responses to a witnessed or reported abuse. Emphasis was on protecting the resident, removing the perpetrator, and reporting immediately. Interview with the Staff Development Coordinator (SDC), on 04/23/13 at 2:27 PM, revealed she had conducted abuse training for every staff member in every department. In order to reach all staff quickly, training was provided in a variety of ways, including classroom setting, telephone inservice, and person-to-person training on the units and in all departments. Continued interview and review of the inservice agenda revealed topics covered included, but were not limited to the different types of abuse, identifying suspicious behaviors,	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	Continued From page 21 how to respond if abuse is observed or suspected, protecting the resident, and reporting to the Charge Nurse, the Administrator, the Social Services Director and the DON. Continued interview with SDC and review of sign-in sheets revealed three (3) staff members had not yet received the training: one was on maternily leave, one was on vacation, and one was a PRN (as needed) staff who had not worked since the incident. Staff signatures were confirmed by cross-check with a master list of facility employees. Document review verified the PIN numbers required for clocking in had been changed by the facility for the three (3) staff still requiring the training. A notice was posted at the time clock instructing these staff to report to the SDC, DON, ADON or Administrator prior to reporting to their unit of duty.  9. Review of the sign-in sheets revealed all Nurses who served in a supervisory or administrative role attended abuse training on 04/16/13. The training was conducted by the DON and the ADON. Instructional methods included handouts, discussion and a Question and Answer session. Topics included identifying abusive situations, protecting the resident, investigating the incident and reporting to the family, physician and State Agency.	F 223			
	10. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the Abuse Investigation Team consisted of the Administrator, the DON, the ADON and the Social Services Director (SSD). All allegations of abuse were to be reviewed daily, seven days a week, to determine who would be in charge of the investigation. Review of the Continuous Quality Improvement				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223	<p>Continued From page 22</p> <p>(CQI) tool for "Abuse Investigation and Reporting" and continued interview with the Administrator revealed the tool would be used for every allegation of abuse. The CQI tool included a checklist to ensure every step in the investigation process, including but not limited to identifying the concern, protecting the resident, suspension of an alleged employee perpetrator, contacting the physician and family, investigating the incident and reporting to the appropriate State Agency.</p> <p>11. Interview with the Quality Assurance (QA) Nurse, on 04/23/12 revealed the Medical Director was very involved with the QA committee. He attended at least quarterly, but usually every month. Review of QA meeting sign-in sheets confirmed his attendance, either in person or by phone. She stated the Medical Director took an active role by making recommendations and reviewing policy changes. Interview with the Medical Director, on 04/18/13 at 3:08 PM, revealed all allegations of abuse were discussed in monthly QA meetings. He stated there had not been a formal QA meeting related to the incident of 04/12/13 but a meeting was scheduled for the following day. He further stated he had been in close contact with the Administrator thus far in the follow up to the incident, and been active in interviewing and examining every resident. Interview with the Administrator, on 04/24/13 at 9:48 AM, revealed the facility's QA committee met on 04/17/13 to review the incident of 04/12/13. Review of the sign-in sheet revealed the meeting was attended by the Administrator, the DON, the ADON, the QA Nurse, and the Social Services Department. The sign-in sheet indicated the Medical Director attended via telephone. The Administrator stated the meeting included a</p>	F 223			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 27</p> <p>months ago (01/25/13), SRNA #1 had straddled him/her in the bed. However, based on Resident #2's history of confusion; seeing things that weren't there; being treated for a Urinary Tract Infection at the time of the allegation; and, the fact the resident later denied the allegation, the Administrator determined the allegation was not credible and decided not to conduct an investigation or report the allegation to the required regulatory agencies. Therefore, the alleged perpetrator was not suspended and continued to provide direct resident care.</p> <p>Review of the staffing schedule for January 2013 revealed SRNA #1 was working the night shift on 01/25/13 on the East Hall where Resident #2 resided. Continued review revealed SRNA #1 worked the 11-7 shift on the East Hall nearly every night, including 01/01/13 through 01/10/13, and 01/15/13 through 01/31/13. Continued review of the staffing schedule revealed SRNA #1 continued working regularly, up to and including the night shift of 04/12/13.</p> <p>On 04/12/13, the State Survey Agency received a report from the facility of a "possible sexual assault" when an employee was observed in a "compromising position" with Resident #1.</p> <p>Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed on 04/12/13, at approximately 2:45 AM, the House Supervisor (HS)/RN #1 on the night shift entered Resident #1's room and observed SRNA #1 with his belt unbuckled and an erection visible through his pants.</p> <p>Interview with RN #1, on 04/17/13 at 9:15 AM, revealed the resident's bottom was at the edge of</p>	F 225	<p>investigator through all aspects. If the Administrator is unavailable, the DON or Social Services Director will complete the checklist. Any item on the checklist determined to be incomplete shall be corrected under the supervision of the Administrator and the appropriate team member re-educated.</p> <p>-The Administrator will complete an allegation checklist audit for 100% of the allegations made and investigated.</p> <p>-The CQI indicator for the monitoring of compliance with the components of the abuse regulation including, but not limited to, investigating and reporting of abuse, will be utilized weekly X 4 weeks and then monthly thereafter under the supervision of the Administrator.</p> <p>-The findings of the completed allegation checklists and CQI indicators will be reviewed by the corporate contracted nurse consultant with monthly visits, to determine that allegations were investigated and reported as indicated.</p> <p>-In the event of an allegation checklist found to be incomplete and/or the CQI Indicator fails to meet threshold, the Administrator, with guidance from the nurse consultant, will formulate a Plan of Action and present it to the QA committee for review and recommendations.</p> <p>-The Administrator developed a Plan of Correction checklist to assure ongoing completion of corrective action on a weekly basis. All corrective actions are included. The checklist will be completed monthly x 4. The Administrator will report the results to the QA Committee monthly.</p> <p>Criterion 5:</p>	4/26/13	

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 28</p> <p>the bed and his/her legs were bent at the hips and the knees, and the resident's knees were apart and up in the air. Per interview, SRNA #1 was standing between Resident #1's legs in a crouching position, with his knees bent slightly and one hand on each of the resident's legs.</p> <p>During an interview with Resident #1, on 04/12/13 at 4:50 PM, the resident stated "I was raped last night". On continued interview, Resident #1 stated there was one other incident "a long time ago" and she named SRNA #1 by name. The resident stated "he hurt me up inside" and SRNA #1 said if the resident told anyone, he would just say the resident was lying.</p> <p>Interview with the Medical Director, on 04/16/13 at 3:10 PM, revealed he recalled Resident #2 had made an allegation of some sort, and he knew the facility did some sort of investigation. However, interview with the Administrator revealed no investigation had been completed.</p> <p>Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the Administrative Team including the Administrator, DON, ADON and Social Worker were involved in the investigations of abuse and had been educated by the contracted Nurse Consultant related to identifying, reporting and investigating allegations of abuse. She further stated she was not involved in the interviews with Resident #2; however both Social Workers reported Resident #2 denied SRNA #1 got into bed with him/her bed and stated "I wish he/she (Resident #2) had said something". The Administrator further stated, because Resident #2 did not continue to claim an allegation against SRNA #1, no further</p>	F 225			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 29</p> <p>investigation was warranted. She stated the facility stopped, but should have investigated further to ensure other residents were protected.</p> <p>The facility provided an acceptable AOC on 04/23/13 with an alleged removal of the IJ on 04/18/13. Review of the AOC by the State Survey Agency revealed the facility implemented the following actions:</p> <ol style="list-style-type: none"> <li>1. The facility immediately initiated an investigation on 04/12/13 at 2:45 AM. The Police Department (PD), the Department for Community Based Services (DCBS), the Office of the Inspector General (OIG, referred to as State Agency), and the Medical Director were notified.</li> <li>2. Residents #1 and #2 were sent to the hospital for evaluation on 04/12/13. Both residents returned to the facility the same day and were offered follow-up counseling by the consultant Psychiatric Services and/or the Rape Crisis Center.</li> <li>3. The identified staff member was removed immediately and sent a certified letter terminating his employment on 04/13/13.</li> <li>4. All residents were interviewed by the Medical Director to determine if they had experienced any potential negative effects related to the allegation. All residents, except six (6) who refused, were physically examined by the Medical Director, beginning 04/12/13 and completed on 04/15/13.</li> <li>5. The Social Services staff completed the PHQ9 interview, or the PHQ9-QV Assessment for mood/anxiety on 04/12/13. No resident had a</li> </ol>	F 225			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 30 score on the PHQ9 Interview or the PHQ9-OV Assessment that indicated any mood or anxiety concerns. The facility was to repeat the interviews/assessments in one week and in two weeks, to evaluate for any delayed effects experienced by the residents.  6. The families and/or responsible parties for all residents were contacted and informed of the allegation. The Social Services staff, the Director of Nursing, and the Assistant Director of Nursing phoned each party beginning on 04/12/13. Any family and/or responsible party that could not be reached by phone by 04/16/13 was sent a certified letter on 04/17/13.  7. The facility employed a security officer for the night shift, beginning 04/13/13 and ongoing. In addition, increased staff on the night shift for added security, beginning 04/12/13.  8. All facility staff was inservice on abuse and the facility's abuse policy, including, but not limited to: identification, protection of residents, and reporting of abuse, as provided by the Staff Development Coordinator on 04/12/13 through 04/16/13. Any staff on leave, vacation, or unavailable for the inservice was locked out of the time clock, and will not be able to clock in or work until completing the inservice education.	F 225			
	9. All nurse supervisors and administrative nurses received inservice education on the investigation and reporting of abuse as provided by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 04/18/13, including but not limited to: identification of events requiring investigation;				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	[X2] MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		[X3] DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 31 Interviewing of residents, staff and all witnesses; and reporting of allegations and findings.  10. All allegations are to be reviewed seven (7) days per week by the facility's investigation team, consisting of the Administrator, the Social Service Director, the DON and the ADON, to determine which team members will investigate and report the allegation to the required authorities.  11. The facility's Quality Assurance Committee, with the Medical Director, met on 04/17/13 to review the circumstances of the allegation and all interventions which had been or would be implemented by the facility.  12. The CQI indicator for the monitoring of compliance with the components of the abuse regulation, including, but not limited to, investigating and reporting of abuse, are to be utilized with each allegation. The CQI indicator is to be used at least weekly for four (4) weeks, then monthly under the supervision of the Administrator.  The State Survey Agency validated the implementation of the facility's AOC as follows:  1. Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed she had called 911 immediately after receiving the report of the incident, related to Resident #1. She stated the PD responded immediately. Interview with the Lead Detective, on 04/15/13 at 1:40 PM, revealed he had assumed charge of the investigation on the morning of 04/12/13, from the night shift officer who responded to the 911 call.	F 225			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185444</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/24/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 32</p> <p>2. A review of hospital records revealed Resident #1 and Resident #2 were evaluated in the ED and transferred back to the facility on 04/12/13. Interview with Resident #2, on 04/23/13 at 2:50 PM revealed a lot of people had been talking to her, but she did not remember who. Interview with Resident #1, on 04/23/13 at 3:00 PM, revealed she had talked to the Rape Crisis Counselor. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed she had spoken with the Rape Crisis Counselor in the facility on 04/15/13 and 04/16/13. She stated the counselor had a private interview with Resident #1 on 04/18/13 and would return weekly as needed. She further stated Resident #2 refused the service. Interview with the contracted Psychiatric Services physician, on 04/16/13 at 3:20 PM, revealed he had seen and evaluated Resident #1 and Resident #2 on that day.</p> <p>3. Interviews with LPN #2 on 04/16/13 at 3:45 PM, RN #1 on 04/17/13 at 9:15 AM, and RN #2 on 04/21/13 at 8:30 PM revealed SRNA #1 left the facility immediately after the incident and had not returned. RN #2 observed SRNA #1 leave via the side exit. LPN #2 went into the parking lot and confirmed SRNA #1's car was gone. Review of the letter addressed to SRNA #1, dated 04/12/13, revealed the following: "Effective immediately, you are no longer an employee of (this facility). You are not to come to this facility for any reason. Your pay check will be mailed to you." The letter was signed by the Administrator. A review of the Certified Letter ticket confirmed the letter was sent as alleged.</p> <p>4. Review of the Physician's notes revealed he interviewed all one hundred and one (101)</p>	F 225			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185444</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/24/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 CAMBRIDGE DRIVE</b> <b>LEXINGTON, KY 40504</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 33</p> <p>residents in the facility between 04/12/13 and 04/15/13. A physical examination was performed on ninety-five (95) residents, six (6) residents refused the examination, but did participate in the interview. Continued review revealed only Resident #1 and Resident #2 had identified concerns. All other residents denied any inappropriate sexual behavior or abuse. All physical exams were normal; specifically, there was no bleeding, bruising, discharge or excoriation. During interview on 04/16/13 at 3:10 PM, the Physician confirmed the resident interviews and examinations were completed.</p> <p>5. Review of the MDS Section D for Mood (PHQ-9) revealed every resident was assessed on 04/12/13 and again one week later, on 04/19/13. Continued review revealed no immediate or delayed reactions to the incident were identified. The assessments included standardized questions related to mood and open-ended questions to identify any specific problems or anxiety. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the assessments would be performed again at the two (2) week mark, on 04/26/13,</p> <p>6. Interview with SW #1, on 04/15/13 at 3:40 PM, revealed she was in the process of contacting the families/responsible parties of all resident regarding the incident on 04/12/13. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed only five (5) families had not been contacted by 04/16/13. Certified letters were sent to these families on 04/17/13, confirmed by review of the postal tickets. Review of the letter, dated 04/17/13 and signed by the Administrator revealed the families were being contacted by</p>	F 225			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 225	Continued From page 34 letter as the facility had been unable to reach them by phone. Continued review revealed the addressees were informed of an alleged sexual assault at the facility and measures were being taken to ensure all residents were protected. Contact information for any questions or concerns was included.  7. Interview with LPN #2 on 04/16/13 at 3:47 PM, SRNA #2 on 04/18/13 at 10:24 AM, SRNA #4 on 04/18/13 at 10:56 AM, and RN #2 on 04/21/13 at 8:30 AM, revealed a security guard was present on the night shift since the incident. In addition, extra staff was on duty at night for added security. Continued interview revealed the security guard and staff patrolled the building and the grounds throughout the night, ensured doors and windows were secure, and checked with staff for any problems. Interview with the Administrator, on 04/24/13 at 9:40 am revealed the security guard had been hired through a local security service and was on duty 10:00 PM until 6:00 AM. In addition, an extra staff person, e.g. Maintenance, Housekeeping, or SRNA was on duty on the night shift, from 11:00 PM until 7:00 AM. She stated male staff who exhibited a strong presence were chosen for the extra shifts at night.  8. Interviews with LPN #1 on 04/15/13 at 2:15 PM, LPN #2 on 04/16/13 at 3:47 PM, RN #1 on 04/17/13 at 9:15 AM, SRNA #2 on 04/18/13 at 10:24 AM, SRNA #6 on 04/23/13 at 1:32 PM, East Wing Unit Coordinator on 04/18/13 at 2:15 PM, and SRNA #5 on 04/23/13 at 3:50 PM, revealed all had attended mandatory inservices since the incident of 04/12/13. The training included appropriate responses to a witnessed or reported abuse. Emphasis was on protecting the	F 225			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 35 resident, removing the perpetrator, and reporting immediately. Interview with the Staff Development Coordinator (SDC), on 04/23/13 at 2:27 PM, revealed she had conducted abuse training for every staff member in every department. In order to reach all staff quickly, training was provided in a variety of ways, including classroom setting, telephone inservice, and person-to-person training on the units and in all departments. Continued interview and review of the inservice agenda revealed topics covered included, but were not limited to the different types of abuse, identifying suspicious behaviors, how to respond if abuse is observed or suspected, protecting the resident, and reporting to the charge nurse, the Administrator, the Social Services Director and the DON. Continued interview with SDC and review of sign-in sheets revealed three (3) staff members had not yet received the training: one was on maternity leave, one was on vacation, and one was a PRN (as needed) staff who had not worked since the incident. Staff signatures were confirmed by cross-check with a master list of facility employees. Document review verified the PIN numbers required for clocking in had been changed by the facility for the three (3) staff still requiring the training. A notice was posted at the time clock instructing these staff to report to the SDC, DON, ADON or Administrator prior to reporting to their unit of duty.	F 225			
	9. Review of the sign-in sheets revealed all nurses who served in a supervisory or administrative role attended abuse training on 04/16/13. The training was conducted by the DON and the ADON. Instructional methods included handouts, discussion and a Question				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 36 and Answer session. Topics included identifying abusive situations, protecting the resident, investigating the incident and reporting to the family, physician and State Agency.  10. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the Abuse Investigation Team consisted of the Administrator, the DON, the ADON and the Social Services Director (SSD). All allegations of abuse were to be reviewed daily, seven days a week, to determine who would be in charge of the investigation. Review of the Continuous Quality Improvement (CQI) tool for "Abuse Investigation and Reporting" and continued Interview with the Administrator revealed the tool would be used for every allegation of abuse. The CQI tool included a checklist to ensure every step in the investigation process, including but not limited to identifying the concern, protecting the resident, suspension of an alleged employee perpetrator, contacting the physician and family, investigating the incident and reporting to the appropriate State Agency.  11. Interview with the Quality Assurance (QA) nurse, on 04/23/12 revealed the Medical Director was very involved with the QA committee. He attended at least quarterly, but usually every month. Review of QA meeting sign-in sheets confirmed his attendance, either in person or by phone. She stated the Medical Director took an active role by making recommendations and reviewing policy changes. Interview with the Medical Director, on 04/16/13 at 3:08 PM, revealed all allegations of abuse were discussed in monthly QA meetings. He stated there had not been a formal QA meeting related to the incident of 04/12/13 but is had been scheduled for the	F 225			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 37 following day. He further stated he had been in close contact with the Administrator thus far in the follow up to the incident, and been active in interviewing and examining every resident. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the facility's QA committee met on 04/17/13 to review the incident of 04/12/13. Review of the sign-in sheet revealed the meeting was attended by the Administrator, the DON, the ADON, the QA nurse, and the Social Services Department. The sign-in sheet indicated the Medical Director attended via telephone. The Administrator stated the meeting included a detailed review of the AOC as it had been completed on that date. Subsequent revisions were made prior to the AOC being accepted by the State Survey Agency. The Administrator stated the Medical Director was in agreement with the AOC and had no additional recommendations.  12. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the CQI tool for Abuse Investigating and Reporting would be utilized with every allegation. Results would be reviewed weekly for four (4) weeks, and monthly thereafter. All results were to be reported to and reviewed with the contracted Nurse Consultant during her monthly visits. The next QA meeting was scheduled for 04/26/13.	F 225			
F 226 SS=J	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 38  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure the implementation of policies and procedures to prohibit abuse for two (2) of five (5) sampled residents (Resident #1 and #2).  On 01/25/13, the facility received an allegation of abuse from Resident #2, who reported State Registered Nurse Aide (SRNA) #1 got in his/her bed and straddled him/her. Two (2) Social Workers (SW) interviewed Resident #2 and gave written accounts of their conversations with the resident. During interview with SW #1, and upon review of the written statements, it was revealed both SWs reported Resident #2 referred to a leaking water heater over his/her head that needed to be fixed immediately, as evidence Resident #2 had hallucinations. Interviews with Administrative Staff revealed they determined, based on the SW interviews, the resident's confusion and changing of the story, and SRNA #1's adamant denial of the incident, there was not a credible allegation to be thoroughly investigated or reported. SRNA #1 was allowed to continue working in an unrestricted manner. No further documented evidence related to an investigation was provided.  On 04/12/13, the House Supervisor (HS)/Registered Nurse (RN) #1 observed Resident #1 to be lying sideways on the bed, and	F 226	<b>F 226 Abuse</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  Criterion 1: -The local police department, Department for Community Based Services, and Office of Inspector General were all notified of the allegation on 4-12-13. The facility immediately initiated investigations on 4-12-13 at 2:45 a.m.; the local police arrived shortly thereafter and began investigating as well. The Medical Director was contacted at 3:15 a.m. -Residents # 1 and 2 were sent to the hospital for evaluation and assessment on 4/12/13. Both returned to the facility on the same day and were offered/received follow-up counseling by the psychiatric consultant services and/or the Rape Crisis Center. -The identified staff member was removed immediately and sent a certified letter terminating his employment on 4-13-13.  Criterion 2: -All residents were interviewed by the Medical Director to determine if they had experienced any potential negative effects related to this allegation. All residents, except 6 who refused, have been physically examined by the Medical Director, with documentation of all interview and assessment findings. The	

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

PRINTED: 06/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IO# COMPLETION DATE	
F 226	<p>Continued From page 39</p> <p>State Registered Nursing Assistant (SRNA) #1 was standing between Resident #1's open legs. During interview, RN #1 revealed SRNA #1 immediately began adjusting his pants and moved away from Resident #1. RN #1 stated she turned on the light and noted SRNA #1 had an erection which was clearly visible through his pants, and his belt was open with the ends of the belt hanging down on either side. Resident #1 reported SRNA #1 was giving therapy "on my bottom". The resident further reported SRNA #1 gave him/her therapy about once a week. Interview with the investigating detective revealed SRNA #1 was arrested and charged under the Elder Justice Act, which prohibits abuse, and a criminal investigation was ongoing.</p> <p>(Refer to F223 and F225)</p> <p>Based on the findings, the facility's failure to implement its policy related to identifying, investigating, and reporting an allegation of abuse on 01/25/13 has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 04/15/13, and was determined to exist on 01/25/13. The facility was notified of the Immediate Jeopardy on 04/15/13.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) on 04/23/13, with the facility alleging the IJ had been removed on 04/18/13. On 04/24/13, the State Survey Agency verified the IJ was removed on 04/18/13 as alleged, with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, F-226 at a Scope and Severity (S/S) of an "D" while the</p>	F 226	<p>Interviews/exams were performed by the Medical Director on 4/12/13, 4/13/12, 4/14/12 and completed on 4/15/13. No residents exhibited emotional, verbal or physical indications of harm.</p> <p>-All residents have had completion of the PHQ9 interview, or the PHQ9-OV staff assessment for mood/anxiety, as completed by the Social Services staff on 4-12-13, to identify any who may be experiencing distress/anxiety related to the reported allegation. Residents were also asked questions during these interviews/assessments to determine if they had any concerns regarding their care or caregivers, if they felt safe in the facility, or if they had any concerns related to abuse. No residents had a score on the PHQ9 or PHQ9-OV that indicated any mood or anxiety issues.</p> <p>The PHQ9 interview and/or PHQ9-OV assessment and interview questions pertaining to care/caregivers and any concerns related to abuse, will be redone again in 1 week, and in 2 weeks by the Social Service staff to determine that there are no delayed effects experienced by the residents.</p> <p>-The families/responsible parties for all residents were contacted and informed of the allegation on 4-12-13, 4-15-13 and 4-16-13 by the Social Service staff, the DON and the ADON. Certified letters were sent on 4-17-13 to any families who could not be reached by telephone.</p> <p>-The facility increased security on the night shift with facility staff on 4-12-13 and a security officer service was employed by the facility for the night shift on 4-13-13.</p> <p>Criterion 3: -All facility staff were inserviced on abuse and the facility abuse policy, including, but not limited to: identification, protection of residents, and reporting of abuse, as</p>		

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 40 facility develops and implements its Plan of Correction and the facility's Quality Assurance Program continues to monitor and ensure residents are protected from abuse.  The findings include:  Review of the facility's policy titled "Policy on Abuse", undated, revealed sexual abuse was defined as, but not limited to, sexual harassment, sexual coercion or sexual assault. Continued review revealed the facility would actively promote the absence of abuse from all individuals. Processes developed to assure the policy was upheld included the following: screening of potential employees; initial and ongoing training of employees; prevention of abuse, neglect, or mistreatment; identification of suspicious events; protection of residents during an investigation; investigation of all alleged violations; and reporting of abusive situations to the required regulatory agencies. Further review revealed policy specifics included but were not limited to the following: any employee involved in an allegation of abuse or neglect would be suspended immediately pending investigation; a thorough examination of the resident would be conducted for any marks, bruises or other injury; the Physician and the resident's legal representative would be notified; and all allegations and investigation results would be reported to the appropriate State Agency, including the State Survey Agency.  Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed Resident #2 alleged, a few months ago (01/25/13), that SRNA #1 had straddled him/her in the bed. The Administrator	F 226	provided by the Staff Development Coordinator on 4/12/13 - 4/16/13. Any staff on leave, vacation, or unavailable for the inservice has been locked out of the time clock, and will not be able to clock in or work until completing the inservice education. -All nurse supervisors and administrative nurses have received inservice education on the investigation and reporting of abuse as provided by the DON and ADON on 4-16-13, including but not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses; and reporting of allegations and findings.  Criterion 4: -All allegations will be reviewed by the facility investigation team (Administrator, Social Service Director, DON and ADON) to determine which team members will investigate and report the allegation to the required authorities seven days per week. -The facility QA Committee, with the Medical Director, convened on 4-17-13 at 9:20 a.m. to review the circumstances of the allegation and all interventions which have been and will be implemented by the facility. The facility QA Committee met again on 5-23-13 with the Medical Director for the regularly scheduled QA Committee Meeting. -The Administrator shall complete an allegation checklist with each allegation investigation to determine that facility policy and procedure was accurately and thoroughly followed. The checklist details the required steps of the investigation process from beginning to end to step the investigator through all aspects. If the Administrator is unavailable, the DON or Social Services Director will complete the checklist. Any item on the checklist determined to be incomplete shall be corrected under the supervision of the Administrator and the appropriate team member re-educated. -The Administrator will complete an allegation checklist audit for 100% of the allegations made		

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 41</p> <p>further stated two Social Workers (SW) went immediately to interview the resident, who then denied the allegation. The Administrator stated she had discussed the matter with the Social Workers and they determined the initial allegation by Resident #2 was not valid. She further stated the facility declined to conduct a formal investigation, did not suspend the alleged perpetrator, and did not report the allegation to the State Agency. Further interview, on 04/15/13 at 3:05 PM, the Administrator stated she had concluded the initial allegation had no merit, i.e. was not credible, and no further investigation or reporting was warranted. However, review of the facility's policy revealed the facility would investigate all alleged violations, and report abusive situations to the required regulatory agencies.</p> <p>During interview, on 04/12/13 at 5:05 PM, Resident #2 stated SRNA #1 got in his/her bed and straddled him/her, with one leg on each side. The resident reported he/she told SRNA #1, "you better get off me!", and he did. Resident #2 stated "it was at least a couple of weeks ago". The resident further stated he/she reported the incident when it occurred, but could not say who he/she reported to, and did not recall anything about an investigation.</p>	F 226	<p>and investigated.</p> <p>-The CQI Indicator for the monitoring of compliance with the components of the abuse regulation including, but not limited to, investigating and reporting of abuse, will be utilized weekly X 4 weeks and then monthly thereafter under the supervision of the Administrator.</p> <p>-The findings of the completed allegation checklists and CQI Indicators will be reviewed by the corporate contracted nurse consultant with monthly visits, to determine that allegations were investigated and reported as indicated.</p> <p>-In the event of an allegation checklist found to be incomplete and/or the CQI Indicator fails to meet threshold, the Administrator, with guidance from the nurse consultant, will formulate a Plan of Action and present it to the QA committee for review and recommendations.</p> <p>-The Administrator developed a Plan of Correction checklist to assure ongoing completion of corrective action on a weekly basis. All corrective actions are included. The checklist will be completed monthly x 4. The Administrator will report the results to the QA Committee monthly.</p> <p>Criterion 5:</p>	4/26/13	
	<p>Review of the staffing schedule for January 2013 revealed SRNA #1 was working the night shift on 01/25/13 on the East Hall where Resident #2 resided. Continued review revealed SRNA #1 worked the 11-7 shift on the East Hall nearly every night, including 01/01/13 through 01/10/13, and 01/15/13 through 01/31/13. Further review revealed SRNA #1 continued working regularly,</p>				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 42</p> <p>up to and including the night shift of 04/12/13. However, review of the facility's policy revealed any employee involved in an allegation of abuse or neglect would be suspended immediately pending investigation.</p> <p>On 04/12/13 at 2:45 AM, SRNA #1 was found in a "compromising position" with Resident #1.</p> <p>Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed the House Supervisor (HS)/RN #1 entered Resident #1's room and observed SRNA #1 with his belt unbuckled and an erection visible through his pants. Resident #1 told RN #1 SRNA #1 was giving him/her therapy "on my bottom". The resident further reported SRNA #1 gave him/her therapy about once a week.</p> <p>During interview, on 04/12/13 at 4:50 PM, Resident #1 stated "I was raped last night" and there was one other incident "a long time ago". Resident #1 referred to SRNA #1 by name and stated SRNA #1 said if the resident told anyone, he would just say the resident was lying.</p> <p>Interview with the Medical Director, on 04/16/13 at 3:10 PM, revealed he recalled Resident #2 had made an allegation of some sort in the past, but he did not recall the details, and he had not interviewed Resident #2 at that time. He stated he was not aware of the regulations related to reporting allegations to the State Agency. He recalled the facility felt Resident #2 was confused when the allegation was made, talked about a radiator, and was being treated for a Urinary Tract Infection. However, while interviewing Resident #2 on 04/12/13, the resident reported again that someone, an employee, straddled him/her some</p>	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 43</p> <p>time ago. The resident stated he/she told the perpetrator, "get off you SOB".</p> <p>The facility provided an acceptable AOC on 04/23/13 with an alleged removal of the IJ on 04/18/13. Review of the AOC by the State Survey Agency revealed the facility implemented the following actions:</p> <ol style="list-style-type: none"> <li>1. The facility immediately initiated an investigation on 04/12/13 at 2:45 AM. The Police Department (PD), the Department for Community Based Services (DCBS), the Office of the Inspector General (OIG, referred to as State Agency), and the Medical Director were notified.</li> <li>2. Residents #1 and #2 were sent to the hospital for evaluation on 04/12/13. Both residents returned to the facility the same day and were offered follow-up counseling by the consultant Psychiatric Services and/or the Rape Crisis Center.</li> <li>3. The identified staff member was removed immediately and sent a certified letter terminating his employment on 04/13/13.</li> <li>4. All residents were interviewed by the Medical Director to determine if they had experienced any potential negative effects related to the allegation. All residents, except six (6) who refused, were physically examined by the Medical Director, beginning 04/12/13 and completed on 04/15/13.</li> <li>5. The Social Services staff completed the PHQ9 interview, or the PHQ9-OV Assessment for mood/anxiety on 04/12/13. No resident had a score on the PHQ9 interview or the PHQ9-OV</li> </ol>	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 228	Continued From page 44 Assessment that indicated any mood or anxiety concerns. The facility was to repeat the interviews/assessments in one week and in two weeks, to evaluate for any delayed effects experienced by the residents.  6. The families and/or responsible parties for all residents were contacted and Informed of the allegation. The Social Services staff, the Director of Nursing, and the Assistant Director of nursing phone each party beginning on 04/12/13. Any family and/or responsible party that could not be reached by phone by 04/16/13 was sent a certified letter on 04/17/13.  7. The facility employed a security officer for the night shift, beginning 04/13/13 and ongoing. In addition, increased staff on the night shift for added security, beginning 04/12/13.  8. All facility staff were inservice on abuse and the facility abuse policy, including, but not limited to: Identification, protection of residents, and reporting of abuse, as provided by the Staff Development Coordinator on 04/12/13 through 04/16/13. Any staff on leave, vacation, or unavailable for the inservice was locked out of the time clock, and will not be able to clock in or work until completing the inservice education.	F 226			
	9. All nurse supervisors and administrative nurses received inservice education on the investigation and reporting of abuse as provided by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 04/16/13, including but not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses;				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG F 226	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 226	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Continued From page 45 and reporting of allegations and findings.</p> <p>10. All allegations are to be reviewed seven days per week by the facility investigation team, consisting of the Administrator, the Social Service Director, the DON and the ADON, to determine which team members will investigate and report the allegation to the required authorities.</p> <p>11. The facility's Quality Assurance Committee, with the Medical Director, met on 04/17/13 to review the circumstances of the allegation and all interventions which had been or would be implemented by the facility.</p> <p>12. The CQI Indicator for the monitoring of compliance with the components of the abuse regulation, including, but not limited to, investigating and reporting of abuse, are to be utilized with each allegation. The CQI indicator is to be used at least weekly for four (4) weeks, then monthly under the supervision of the Administrator.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed she had called 9-1-1 immediately after receiving the report of the incident. <del>She stated the PD responded immediately.</del> Interview with the Lead Detective, on 04/15/13 at 1:40 PM, revealed he had assumed charge of the investigation on the morning of 04/12/13, from the night shift officer who responded to the 9-1-1 call.</p> <p>2. A review of hospital records revealed Resident</p>				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 46 #1 and Resident #2 were evaluated in the ED and transferred back to the facility on 04/12/13. Interview with Resident #2, on 04/23/13 at 2:50 PM revealed a lot of people had been talking to her, but she did not remember who.  Interview with Resident #1, on 04/23/13 at 3:00 PM, revealed she had talked to the Rape Crisis Counselor. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed she had spoken with the Rape Crisis Counselor in the facility on 04/15/13 and 04/16/13. She stated the counselor had a private interview with Resident #1 on 04/16/13 and would return weekly as needed. She further stated Resident #2 refused the service.  Interview with the contracted Psychiatric Services physician, on 04/16/13 at 3:20 PM, revealed he had seen and evaluated Resident #1 and Resident #2 on that day.  3. Interviews with LPN #2, on 04/16/13 at 3:45 PM, RN #1 on 04/17/13 at 9:15 AM, and RN #2 on 04/21/13 at 8:30 PM revealed SRNA #1 had left the facility immediately after the incident and had not returned. RN #2 observed SRNA #1 leave via the side exit. LPN #2 went into the parking lot and confirmed SRNA #1's car was gone. Review of the letter addressed to SRNA #1, dated 04/12/13, revealed the following: "Effective immediately, you are no longer an employee of (this facility). You are not to come to this facility for any reason. Your pay check will be mailed to you." The letter was signed by the Administrator. A review of the Certified Letter ticket confirmed the letter was sent as alleged.	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 47 4. Review of the Physlcian's notes revealed he interviewed all 101 residents in the facility between 04/12/13 and 04/15/13. A physical exam was performed on 98 residents, 6 residents refused the exam, but did participate in the interview. Continued review revealed only Resident #1 and Resident #2 had identified concerns. All other residents denied any inappropriate sexual behavior or abuse. All physical exams were normal. Specifically, there was no bleeding, bruising, discharge or excoriation.  5. Review of the MDS Section D for Mood (PHQ-9) revealed every resident was assessed on 04/12/13 and again one week later, on 04/19/13. Continued review revealed no immediate or delayed reactions to the incident were identified. The assessments included standardized questions related to mood and open-ended questions to identify any specific problems or anxiety. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the assessments would be performed again at the two week mark, on 04/26/13.  6. Interview with SW #1, on 04/15/13 at 3:40 PM, revealed she was in the process of contacting the families / responsible parties of all resident regarding the incident on 04/12/13. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed only five (5) families had not been contacted by 04/16/13. Certified Letters were sent to these families on 04/17/13, confirmed by review of the postal tickets. Review of the letter, dated 04/17/13 and signed by the Administrator revealed the families were being contacted by letter as the facility had been unable to reach	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 48 them by phone. Continued review revealed the addressees were informed of an alleged sexual assault at the facility and measures were being taken to ensure all residents were protected. Contact information for any questions or concerns was included.  7. Interview with LPN #2, on 04/16/13 at 3:47 PM, SRNA #2 on 04/18/13 at 10:24 AM, SRNA #4 on 04/18/13 at 10:56 AM, and RN #2 on 04/21/13 at 8:30 AM, revealed a security guard was present on the night shift since the incident. In addition, extra staff were on duty at night for added security. Continued interview revealed the security guard and staff patrolled the building and the grounds throughout the night, ensured doors and windows were secure, and checked with staff for any problems.  Interview with the Administrator, on 04/24/13 at 9:40 am revealed the security guard had been hired through a local security service and was on duty 10:00 PM until 6:00 AM. In addition, an extra staff person, e.g. Maintenance, Housekeeping, or SRNA was on duty on the night shift, from 11:00 PM until 7:00 AM. She stated male staff who exhibited a strong presence were chosen for the extra shifts at night.  8. Interviews with LPN #1, on 04/15/13 at 2:15 PM, LPN #2 on 04/16/13 at 3:47 PM, RN #1 on 04/17/13 at 9:15 AM, SRNA #2 on 04/18/13 at 10:24 AM, SRNA #6 on 04/23/13 at 1:32 PM, East Wing Unit Coordinator on 04/18/13 at 2:15 PM, and SRNA #5 on 04/23/13 at 3:50 PM, revealed all had attended mandatory inservices since the incident of 04/12/13. The training included appropriate responses to a witnessed or	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 49 reported abuse. Emphasis was on protecting the resident, removing the perpetrator, and reporting immediately.  Interview with the Staff Development Coordinator (SDC), on 04/23/13 at 2:27 PM, revealed she had conducted abuse training for every staff member in every department. In order to reach all staff quickly, training was provided in a variety of ways, including classroom setting, telephone inservice, and person-to-person training on the units and in all departments. Continued Interview and review of the inservice agenda revealed topics covered included, but were not limited to the different types of abuse, identifying suspicious behaviors, how to respond if abuse is observed or suspected, protecting the resident, and reporting to the charge nurse, the Administrator, the Social Services Director and the DON. Continued interview with SDC and review of sign-in sheets revealed three (3) staff members had not yet received the training: one was on maternity leave, one was on vacation, and one was a PRN (as needed) staff who had not worked since the incident. Staff signatures were confirmed by cross-check with a master list of facility employees. Document review verified the PIN numbers required for clocking in had been changed by the facility for the three (3) staff still requiring the training. A notice was posted at the time clock instructing these staff to report to the SDC, DON, ADON or Administrator prior to reporting to their unit of duty.  9. Review of the sign-in sheets revealed all nurses who served in a supervisory or administrative role attended abuse training on 04/16/13. The training was conducted by the	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 50</p> <p>DON end the ADON. Instructional methods included handouts, discussion and a Question and Answer session. Topics included identifying abusive situations, protecting the resident, investigating the incident and reporting to the family, physician and State Agency.</p> <p>10. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the Abuse Investigation Team consisted of the Administrator, the DON, the ADON and the Social Services Director (SSD). All allegations of abuse were to be reviewed daily, seven days a week, to determine who would be in charge of the investigation. Review of the Continuous Quality Improvement (CQI) tool for "Abuse Investigation and Reporting" and continued interview with the Administrator revealed the tool would be used for every allegation of abuse. The CQI tool included a checklist to ensure every step in the investigation process, including but not limited to identifying the concern, protecting the resident, suspension of an alleged employee perpetrator, contacting the physician and family, investigating the incident and reporting to the appropriate State Agency.</p> <p>11. Interview with the Quality Assurance (QA) nurse, on 04/23/12 revealed the Medical Director was very involved with the QA committee. He attended at least quarterly, but usually every month. Review of QA meeting sign-in sheets confirmed his attendance, either in person or by phone. She stated the Medical Director took an active role by making recommendations and reviewing policy changes.</p> <p>Interview with the Medical Director, on 04/16/13 at 3:08 PM, revealed all allegations of abuse were</p>	F 226			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 51 discussed in monthly QA meetings. He stated there had not been a formal QA meeting related to the incident of 04/12/13 but one had been scheduled for the following day. He further stated he had been in close contact with the Administrator thus far in the follow up to the incident, and been active in interviewing and examining every resident.  Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the facility's QA committee met on 04/17/13 to review the incident of 04/12/13. Review of the sign-in sheet revealed the meeting was attended by the Administrator, the DON, the ADON, the QA nurse, and the Social Services Department. The sign-in sheet indicated the Medical Director attended via telephone. The Administrator stated the meeting included a detailed review of the AOC as it had been completed on that date. Subsequent revisions were made prior to the AOC being accepted by the State Survey Agency. The Administrator stated the Medical Director was in agreement with the AOC and had no additional recommendations.  12. Continued interview with the Administrator, on 04/24/13 at 9:10 AM, revealed the CQI tool for Abuse Investigating and Reporting would be utilized with every allegation. Results would be reviewed weekly for four (4) weeks, and monthly thereafter. All results were to be reported to and reviewed with the contracted Nurse Consultant during her monthly visits. The next QA meeting was scheduled for 04/26/13.	F 226		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT	F 273		

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

PRINTED: 06/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 273	<p>Continued From page 52</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility's policy, it was determined the facility failed to ensure an Initial Comprehensive Assessment was conducted for one (1) of five (5) sampled residents (Resident #4), within fourteen (14) calendar days after admission. The facility admitted Resident #4 on 02/28/13; however, review of the clinical record, on 04/23/13, revealed no comprehensive assessment had been completed for Resident #4.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "RAI Completion", undated, revealed it was the policy of the facility to follow Federal and State guidelines for completion of the Resident Assessment Instrument (RAI) in accordance with the Minimum Data Set (MDS) 3.0 Manual:</p> <p>Review of the MDS 3.0 Manual revealed the Admission Comprehensive Assessment must be completed by the fourteenth (14th) calendar day of the resident's admission.</p> <p>Review of the clinical record revealed the facility</p>	F 273	<p><b>F 273 Comprehensive Assessment</b> A facility must conduct a Comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's condition.</p> <p><b>Criteria 1:</b> The admission assessment for resident #4 was completed by the MDS Team on 4/23/13.</p> <p><b>Criteria 2:</b> An audit of all residents admitted within the last 90 days was completed by the DON on 4/25/13 to determine that the admission assessments had been completed. There were no missing admission assessments identified.</p> <p><b>Criteria 3:</b> The MDS Nurses have received inservice education by the DON on 4/25/13 on the completion of admission assessments within 14 days of admission for all new residents.</p> <p><b>Criteria 4:</b> - All new admissions will be reviewed in the facility morning meeting by day 14 of admission to determine that the admission assessment is completed. - The CQI Indicator for the monitoring of the RAI process will be utilized monthly X 2 months, and then every 6 months thereafter in accordance with the CQI calendar, under the supervision of the DON.</p> <p><b>Criteria 5:</b></p>	4/26/13	

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 273	<p>Continued From page 53</p> <p>admitted Resident #4 on 02/28/14, with diagnoses which included Chronic Airway Obstructive Disease, Chronic Kidney Disease, Anxiety, Depression, and Chronic Pain. Continued review, on 04/23/13, revealed no Initial Comprehensive MDS Assessment had been completed.</p> <p>Interview with the MDS Nurse, on 04/23/13 at 1:10 PM, revealed she been in the position since 03/01/13. She stated she did not realize the deadline for Resident #4's comprehensive assessment had passed. She further stated the resident was sent out to the hospital on 03/11/13 and returned on 03/21/13. The fourteen (14) day deadline was 03/14/13 while the resident was out of the facility. On return from the hospital, she completed a Readmission Assessment as instructed, without realizing the Initial Comprehensive Assessment had not been completed. Continued Interview revealed she was not aware of the oversight until it was brought to her attention by the State Agency Surveyor.</p> <p>Interview with the Director of Nursing (DON), on 04/23/13 at 1:13 PM, revealed she was a resource for the new MDS Nurse. She stated the MDS Nurse asked her what type of assessment was due when Resident #4 returned from the hospital. She instructed the MDS Nurse a Readmission Assessment was to be completed after a stay in the hospital when the resident went out and returned under Medicare services. She further stated she had explained the procedure for return from a hospital stay without realizing the Initial Comprehensive Assessment had never been completed.</p>	F 273			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490 SS=J	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of five (5) sampled residents (Resident #1 and Resident #2). The facility failed to ensure policy and procedures were implemented to protect residents from abuse.</p> <p>On 01/25/13, Resident #2 reported an allegation that State Registered Nurse Aide (SRNA) #1 got in his/her bed and straddled him/her. Two (2) Social Workers (SW) interviewed Resident #2 and documented written statements of their conversations with Resident #2. During interview with SW #1, and review of the written statements, it was revealed both SWs reported Resident #2 referred to a leaking water heater over his/her head that needed to be fixed immediately and that Resident #2 had hallucinations. Interviews with Administrative Staff revealed they determined, based on the SW interviews, that the</p>	F 490			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	<p>Continued From page 55</p> <p>resident's confusion and changing of his/her story, and SRNA #1's adamant denial of the incident, there was not a credible allegation to be thoroughly investigated or reported. SRNA #1 was allowed to continue working directly with residents. There was no documented evidence the facility's Administration ensured a thorough investigation was completed to ensure the protection of other residents from potential abuse.</p> <p>On 04/12/13, at approximately 2:45 AM, Registered Nurse (RN) #1 entered the room of Resident #1. She observed Resident #1 to be lying sideways on the bed and State Registered Nursing Assistant (SRNA) #1 was standing between Resident #1's open legs. During interview, RN #1 revealed SRNA #1 immediately began adjusting his pants and moved away from Resident #1. RN #1 stated she turned on the light and noted SRNA #1 had an erection which was clearly visible through his pants and his belt was open with the ends of the belt hanging down on either side. Interview with the investigating detective revealed SRNA #1 was arrested and charged under the Elder Justice Act, which prohibited abuse and a criminal investigation was ongoing.</p> <p>The facility Administration's failure to implement its policy related to identifying, investigating, protecting residents from further abuse and reporting an allegation of abuse against SRNA #1 on 01/25/13 has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 04/15/13 and was determined to exist on 01/25/13. The facility was notified of the Immediate Jeopardy on 04/15/13.</p>	F 490	<p><b>F 490 Administration</b> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p><b>Criterion 1:</b> -The local police department, Department for Community Based Services, and Office of Inspector General were all notified of the allegation on 4-12-13. The facility immediately initiated investigations on 4-12-13 at 2:45 a.m.; the local police arrived shortly thereafter and began investigating as well. The Medical Director was contacted at 3:15 a.m. -Residents # 1 and 2 were sent to the hospital for evaluation and assessment. Both returned to the facility and have been offered/received follow up counseling. -The contracted corporate contracted nurse consultant was contacted on 4-12-13 for notification and review of the allegation, and discussion/planning of all interventions initiated by the Administrator. -The identified staff member was removed immediately and sent a certified letter terminating his employment on 4-13-13.</p> <p><b>Criterion 2:</b> -All residents were interviewed by the Medical Director to</p>	

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 56</p> <p>(Refer to F-223, F-225 and F226)</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) on 04/23/13, with the facility alleging the IJ had been removed on 04/18/13. On 04/24/13, the State Survey Agency verified the IJ was removed on 04/18/13 as alleged with remaining non-compliance 42 CFR 483.75 Administration, F-490 at a Scope and Severity (S/S) of a "D" while the facility developed and implemented its Plan of Correction and the facility's Quality Assurance Program continued to monitor and ensure residents were protected from abuse.</p> <p>The findings include:</p> <p>The facility failed to ensure all alleged violations of mistreatment, neglect, or abuse were thoroughly investigated and reported to the State Agency per facility policy and per regulations. In addition the facility's Administration failed to ensure residents were protected from further abuse.</p> <p>Review of the facility's policy titled "Policy on Abuse", undated, revealed the facility would actively promote the absence of abuse from all individuals; protect residents during an investigation; investigate all alleged violations; and report abusive situations to the required regulatory agencies. Further review revealed any employee involved in an allegation of abuse or neglect would be suspended immediately pending investigation, and all allegations and investigation results would be reported to the appropriate State</p>	F 490	<p>determine if they have experienced any potential negative effects related to this allegation. All residents, except 6 who refused, have been physically examined by the Medical Director, with documentation of all interview and assessment findings. The interviews/exams were performed by the Medical Director on 4/12/13, 4/13/12, 4/14/12, and completed on 4/15/13. No residents exhibited emotional, verbal or physical indications of harm.</p> <p>-All residents have had completion of the PHQ9 interview, or the PHQ9-OV staff assessment for mood/anxiety, as completed by the Social Services staff on 4-12-13, to identify any who may be experiencing distress/anxiety related to the reported allegation. Residents were also asked questions during these interviews/assessments to determine if they had any concerns regarding their care or caregivers, if they felt safe in the facility, or if they had any concerns related to abuse. No residents had a score on the PHQ9, or PHQ9-OV that indicated any mood or anxiety issues. The PHQ9 interview and/or PHQ9-OV assessment, and interview questions pertaining to care/caregivers and any concerns related to abuse, will be redone again in 1 week, and in 2 weeks by the Social Service staff to determine that there are no delayed effects experienced by the residents.</p> <p>-The identified staff member was removed immediately and sent a certified letter terminating his employment on 4-13-13.</p> <p>Criterion 3: -The Administrator, Social Service Director, DON, and ADON received inservice education on the investigation and reporting of abuse as provided by the contracted Nurse Consultant on 4/16/13, including, but not limited to: identification of events</p>		

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	<p>Continued From page 57 Agency, including the State Survey Agency.</p> <p>Interview and record review revealed the facility failed to thoroughly investigate an allegation made by Resident #2, on 01/25/13, that State Registered Nursing Assistant (SRNA) #1 had straddled him/her in the bed. In addition, the Administration failed to report the allegation of abuse to the State Agency.</p> <p>Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed Resident #2 alleged, a few months ago (01/25/13), SRNA #1 had straddled him/her in the bed. She stated two Social Workers (SW) went immediately to interview the resident, who then denied the allegation. Continued interview with the Administrator, on 04/15/13 at 3:05 PM, revealed based on the resident's confusion at the time of the allegation, and the resident changing his/her story, the Administrator concluded the initial allegation had no merit and was not credible, and therefore no further investigation or reporting was warranted.</p> <p>However, interview with the Medical Director, on 04/16/13 at 3:10 PM, revealed while interviewing Resident #2 on 04/12/13, the resident reported again that someone, an employee, straddled him/her some time ago and he/she told the perpetrator, "get off you SOB".</p>	F 490	<p>requiring investigation; interviewing of residents, staff and all witnesses; and reporting of allegations and findings. -All nurse supervisors and administrative nurses have received inservice education on the investigation and reporting of abuse as provided by the DON and ADON on 4-16-13, including but not limited to: identification of events requiring investigation, interviewing of residents, staff and all witnesses; and reporting of allegations and findings.</p> <p><b>Criterion 4:</b> -The facility QA Committee, including the Medical Director, convened on 4-17-13 at 9:20 a.m. to review the circumstances of the events, the response of the administrative staff, the results of the resident interviews and examination and all interventions which have been and will be implemented by the facility. The facility QA Committee met again on 5-23-13 with the Medical Director for the regularly scheduled QA Committee Meeting. -The Administrator shall complete an allegation checklist with each allegation investigation to determine that facility policy and procedure was accurately and thoroughly followed. The checklist details the required steps of the investigation process from beginning to end to step the investigator through all aspects. If the Administrator is unavailable, the DON or Social Services Director will complete the checklist. Any item on the checklist determined to be incomplete shall be corrected under the supervision of the Administrator and the appropriate team member re-educated.</p>	
	<p>Further interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the facility should have investigated the allegation to ensure other residents were protected.</p> <p>Review of the State Agency Intake Information, dated 04/12/13 (approximately three months after</p>		<p>-The Administrator will complete an allegation checklist audit for 100% of the allegations made and investigated. -The CQI Indicator for the monitoring of compliance with the components of the abuse regulation including, but not limited to, investigating and reporting of abuse, will be utilized weekly X 4 weeks and then monthly thereafter under the supervision of the Administrator.</p>	

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	<p>Continued From page 58</p> <p>the allegation made by Resident #2 against SRNA #1), revealed the facility reported an incident of "possible sexual assault" when SRNA #1 was observed in a "compromising position" with Resident #1. During interview, on 04/12/13 at 4:50 PM, Resident #1 stated "I was raped last night" and referred to SRNA #1 by name.</p> <p>The facility provided an acceptable AOC on 04/23/13 with an alleged removal of the IJ on 04/18/13. Review of the AOC by the State Survey Agency revealed the facility implemented the following actions:</p> <ol style="list-style-type: none"> <li>1. The facility immediately initiated an investigation on 04/12/13 at 2:45 AM. The Police Department (PD), the Department for Community Based Services (DCBS), the Office of the Inspector General (OIG, referred to as State Agency), and the Medical Director were notified.</li> <li>2. Residents #1 and #2 were sent to the hospital for evaluation on 04/12/13. Both residents returned to the facility the same day and were offered follow-up counseling by the consultant Psychiatric Services and/or the Rape Crisis Center.</li> <li>3. The contracted Nurse Consultant was contacted on 04/12/13 for notification and review of the allegation, and discussion and planning of all interventions initiated by the Administrator.</li> <li>4. The identified staff member was removed immediately and sent a certified letter terminating his employment on 04/13/13.</li> <li>5. All residents were interviewed by the Medical</li> </ol>	F 490	<p>-The findings of the completed allegation checklists and CQI indicators will be reviewed by the corporate contracted nurse consultant with monthly visits, to determine that allegations were investigated and reported as indicated.</p> <p>-In the event of an allegation checklist found to be incomplete and/or the CQI Indicator fails to meet threshold, the Administrator, with guidance from the nurse consultant, will formulate a Plan of Action and present it to the QA committee for review and recommendations.</p> <p>-The Administrator developed a Plan of Correction checklist to assure ongoing completion of corrective action on a weekly basis. All corrective actions are included. The checklist will be completed monthly x 4. The Administrator will report the results to the QA Committee monthly.</p> <p>-All allegations will be reviewed by the facility investigation team (Administrator, Social Service Director, DON, ADON) to determine which team members will investigate and report the allegation to the required authorities seven days per week. The Administrator will remain informed of the investigation and report all actions to contracted nurse consultant daily for review and consultation.</p> <p>-The Administrator will report all findings and actions of the facility investigation team to the contracted nurse consultant with each allegation to confirm that all necessary investigation and reporting interventions have been initiated. If any issues are noted, further education and consultation will be provided immediately by the contracted nurse consultant.</p> <p>-The nurse consultant will review the Plan of Correction checklist audit results and report to the Board monthly. Corrective action will be immediately initiated as needed and a follow-up report provided to the Board after the following QA meeting.</p> <p>Criterion 5:</p>	4/26/13

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 59</p> <p>Director to determine if they had experienced any potential negative effects related to the allegation. All residents, except six (6) who refused, were physically examined by the Medical Director, beginning 04/12/13 and completed on 04/15/13.</p> <p>6. The Social Services staff completed the PHQ9 interview, or the PHQ9-OV Assessment for mood/anxiety on 04/12/13. No resident had a score on the PHQ9 interview or the PHQ9-OV Assessment that indicated any mood or anxiety concerns. The facility was to repeat the interviews/assessments in one week and in two weeks, to evaluate for any delayed effects experienced by the residents.</p> <p>7. The Administrator, Social Services Director, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were educated on the investigation and reporting of abuse as provided by the contracted Nurse Consultant on 04/16/13. Training topics included, but were not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses; and reporting of allegations and findings.</p> <p>8. All nurse supervisors and administrative nurses received inservice education on the investigation and reporting of abuse as provided by the DON and the ADON on 04/16/13, including but not limited to: Identification of events requiring investigation; Interviewing of residents, staff and all witnesses; and reporting of allegations and findings.</p> <p>9. The facility's Quality Assurance (QA) Committee, with the Medical Director, met on 04/17/13 to review the circumstances of the</p>	F 490			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 60 allegation and all interventions which had been or would be implemented by the facility.  10. All allegations are to be reviewed seven days per week by the facility investigation team, consisting of the Administrator, the Social Service Director, the DON and the ADON, to determine which team members will investigate and report the allegation to the required authorities.  11. The Administrator will report all findings and actions of the facility's investigation team to the contracted Nurse Consultant with each allegation to confirm that all necessary investigation and reporting interventions have been initiated. Further education and consultation will be provided immediately by the Nurse Consultant if any concerns are identified.  12. The CQI indicator for the monitoring of compliance with the components of the abuse regulation, including, but not limited to, investigating and reporting of abuse, are to be utilized with each allegation. The CQI indicator is to be used at least weekly for four (4) weeks, then monthly under the supervision of the Administrator.  The State Survey Agency validated the implementation of the facility's AOC as follows:	F 490			
	1. Interview with the Administrator, on 04/12/13 at 2:10 PM, revealed she had called 9-1-1 immediately after receiving the report of the incident. She stated the PD responded immediately. Interview with the Lead Detective, on 04/15/13 at 1:40 PM, revealed he had assumed charge of the investigation on the				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 61 morning of 04/12/13, from the night shift officer who responded to the 9-1-1 call.</p> <p>2. A review of hospital records revealed Resident #1 and Resident #2 were evaluated in the ED and transferred back to the facility on 04/12/13. Interview with Resident #2, on 04/23/13 at 2:50 PM revealed a lot of people had been talking to her, but she did not remember who.</p> <p>Interview with Resident #1, on 04/23/13 at 3:00 PM, revealed she had talked to the Rape Crisis Counselor, but she did not think she needed to. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed she had spoken with the Rape Crisis Counselor in the facility on 04/15/13 and 04/16/13. She stated the counselor had a private interview with Resident #1 on 04/16/13 and would return weekly as needed. She further stated Resident #2 refused the service.</p> <p>Interview with the contracted Psychiatric Services physician, on 04/16/13 at 3:20 PM, and review of examination notes, revealed he had seen and evaluated Resident #1 and Resident #2 on that day.</p> <p>3. The contracted Nurse Consultant was present in the facility on 04/12/13 when the State Survey Agency began their investigation. She was actively involved in assisting with the survey process and was observed in consultation with the Administrator. During interview, on 04/12/13 at 4:00 PM, the Nurse Consultant revealed the decision had been made for the Medical Director to interview/examine every resident in the facility, not just the female residents on the hall where</p>	F 490			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 62 Resident #2 resided.  4. Interviews with LPN #2, on 04/16/13 at 3:45 PM, RN #1 on 04/17/13 at 9:15 AM, and RN #2 on 04/21/13 at 8:30 PM revealed SRNA #1 had left the facility immediately after the incident and had not returned. RN #2 observed SRNA #1 leave via the side exit. LPN #2 went into the parking lot and confirmed SRNA #1's car was gone. Review of the letter addressed to SRNA #1, dated 04/12/13, revealed the following: "Effective immediately, you are no longer an employee of (this facility). You are not to come to this facility for any reason. Your pay check will be mailed to you." The letter was signed by the Administrator. A review of the Certified Letter ticket confirmed the letter was sent as alleged.  5. Review of the Medical Director's notes revealed he interviewed all 101 residents in the facility between 04/12/13 and 04/15/13. A physical exam was performed on 98 residents, 6 residents refused the exam, but did participate in the interview. Continued review revealed only Resident #1 and Resident #2 had identified concerns. All other residents denied any inappropriate sexual behavior or abuse. All physical exams were normal. Specifically, the absence of bleeding, bruising, discharge or excoriation was documented by the Medical Director.	F 490			
	6. Review of the MDS Section D for Mood (PHQ-9) revealed every resident was assessed on 04/12/13 and again one week later, on 04/19/13. Continued review revealed no immediate or delayed reactions to the incident were identified. The assessments included				

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 63</p> <p>standardized questions related to mood and open-ended questions to identify any specific problems or anxiety. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the assessments would be performed again at the two week mark, on 04/26/13.</p> <p>7. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the contracted Nurse Consultant provided inservice education to the Administrator, the Social Services Director and staff, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), on 04/16/13. Review of the sign-in sheets revealed all parties attended the Inservice. Topics included identification of events requiring investigation; interviewing of residents, staff and all witnesses; and reporting allegations and findings. Methods of instruction included discussion, handouts and a PowerPoint presentation.</p> <p>8. Interviews with LPN #1, on 04/15/13 at 2:15 PM, LPN #2 on 04/16/13 at 3:47 PM, RN #1 on 04/17/13 at 9:15 AM, SRNA #2 on 04/18/13 at 10:24 AM, SRNA #6 on 04/23/13 at 1:32 PM, East Wing Unit Coordinator on 04/18/13 at 2:15 PM, and SRNA #5 on 04/23/13 at 3:50 PM, revealed all had attended mandatory Inservices since the incident of 04/12/13. The training included appropriate responses to a witnessed or reported abuse. Emphasis was on protecting the resident, removing the perpetrator, and reporting immediately.</p> <p>9. Interview with the Quality Assurance (QA) nurse, on 04/23/12 revealed the Medical Director was very involved with the QA committee. He attended at least quarterly, but usually every</p>	F 490			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 64</p> <p>month. Review of QA meeting sign-in sheets confirmed his attendance, either in person or by phone. She stated the Medical Director took an active role by making recommendations and reviewing policy changes.</p> <p>Interview with the Medical Director, on 04/16/13 at 3:08 PM, revealed all allegations of abuse were discussed in monthly QA meetings. He stated there had not been a formal QA meeting related to the incident of 04/12/13 but one had been scheduled for the following day. He further stated he had been in close contact with the Administrator thus far in the follow up to the incident, and been active in interviewing and examining every resident.</p> <p>Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the facility's QA committee met on 04/17/13 to review the incident of 04/12/13. Review of the sign-in sheet revealed the meeting was attended by the Administrator, the DON, the ADON, the QA nurse, and the Social Services Department. The sign-in sheet indicated the Medical Director attended via telephone. The Administrator stated the meeting included a detailed review of the AOC as it had been completed on that date. Subsequent revisions were made prior to the AOC being accepted by the State Survey Agency. The Administrator stated the Medical Director was in agreement with the AOC and had no additional recommendations.</p> <p>10. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the Abuse Investigation Team consisted of the Administrator, the DON, the ADON and the Social Services Director</p>	F 490			

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

PRINTED: 05/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/24/2013
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 65 (SSD). All allegations of abuse were to be reviewed daily, seven days a week, to determine who would be in charge of the investigation. Review of the Continuous Quality Improvement (CQI) tool for "Abuse Investigation and Reporting" and continued interview with the Administrator revealed the tool would be used for every allegation of abuse. The CQI tool included a checklist to ensure every step in the investigation process, including but not limited to identifying the concern, protecting the resident, suspension of an alleged employee perpetrator, contacting the physician and family, investigating the incident and reporting to the appropriate State Agency.  11. Interview with the Administrator, on 04/24/13 at 9:40 AM, revealed the contracted Nurse Consultant visited monthly and would in the future be reviewing all CQI data to verify all investigation interventions and reporting requirements had been initiated. She stated the Nurse Consultant would prepare a report based on the CQI data and report to the facility Board (owners) monthly as well.  12. Continued interview with the Administrator, on 04/24/13 at 9:10 AM, revealed the CQI tool for Abuse Investigating and Reporting would be utilized with every allegation. Results would be reviewed weekly for four (4) weeks, and monthly thereafter. All results were to be reported to and reviewed with the contracted Nurse Consultant during her monthly visits. The next QA meeting was scheduled for 04/26/13.	F 490			

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

PRINTED: 04/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/20/2013
--------------------------------------------------	------------------------------------------------------------------	--------------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 000 INITIAL COMMENTS

CFR: 42 CFR §483.70 (a)

BUILDING: 01

PLAN APPROVAL: 1974

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) Story, Type V (111) Unprotected

SMOKE COMPARTMENTS: Seven (7) smoke compartments.

COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed in 1974

FULLY SPRINKLED, SUPERVISED (Dry SYSTEM) original in 1974

EMERGENCY POWER: Type II Diesel Generator. Original in 1974

A life safety code survey was initiated on 3/19/13 and concluded on 3/20/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred eighteen (118) beds and the census was one hundred eight (108) the day of the survey.

K 000

Disclaimer: Preparation and execution of this plan of correction does not constitute 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.

K025- Facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards.

Criteria 1: The unsealed penetrations to the smoke partitions identified during the survey that extend above the ceiling have been repaired and sealed.

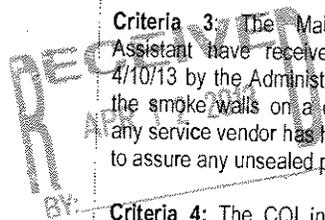
Criteria 2: All smoke walls have been inspected and repaired and sealed with no further issues identified.

Criteria 3: The Maintenance Supervisor and Assistant have received in-service education on 4/10/13 by the Administrator on the need to inspect the smoke walls on a quarterly basis and/or when any service vendor has had access to the attic space to assure any unsealed penetrations are corrected.

Criteria 4: The CQI indicator, which includes the monitoring of smoke walls in the attic to assure there are no unsealed penetrations, shall be completed by the Maintenance Supervisor monthly x 2, then quarterly thereafter under the supervision of the Administrator.

Criteria 5:

5/6/13



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/12/13
--------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------	----------------------

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.

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

PRINTED: 04/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/20/2013
--------------------------------------------------	------------------------------------------------------------------	--------------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 000 Continued From page 1  
Deficiencies were cited with the highest scope and severity of an "F".

K 000

K 025 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F  
Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

K 025

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, ninety-eight (98) residents, staff and visitors. The facility is licensed for one hundred eighteen (118) beds and the census was one hundred eight (108) on the day of the survey.

The findings include:  
Review of the facility's policy titled 'Maintenance Program, not dated, revealed the maintenance staff should keep fire protection systems in a safe and functional condition. Further review of the policy revealed maintenance should keep

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

PRINTED: 04/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/20/2013
--------------------------------------------------	------------------------------------------------------------------	--------------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 025 Continued From page 2  
electrical wiring, cords, and appliances in good working condition.

Observation, on 03/19/13 between 11:05 AM and 11:58 AM, revealed three (3) smoke barriers had penetrations not sealed around sprinkler piping and data wires penetrated the walls. Further observation revealed where the drywall edges met that they were not sealed with material equal or greater than the barrier material, with the potential to not resist the passage of smoke.

Interview, on 03/19/13 at 11:58 AM, with the Maintenance Director revealed he was unaware of the penetrations and needed to start immediately on the repairs.

Reference: NFPA 101 (2000 edition)  
8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:  
(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:  
a. It shall be filled with a material that is capable of limiting the transfer of smoke.  
b. It shall be protected by an approved device that is designed for the specific purpose.  
(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in

K 025

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

PRINTED: 04/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/20/2013
--------------------------------------------------	------------------------------------------------------------------	--------------------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
-----------------------------------------------------	--------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 025 Continued From page 3  
the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:  
a. It shall be filled with a material that is capable of limiting the transfer of smoke.  
b. It shall be protected by an approved device that is designed for the specific purpose.  
(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:  
a. It shall be made on either side of the smoke partitions.  
b. It shall be made by an approved device that is designed for the specific purpose.

K 025