

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/29/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 05/19/15, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

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

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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 461 INDIANA AVE MAYFIELD, KY 42086	
(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 201	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedures, it was determined the facility failed to permit one (1) of five (5) sampled residents (Resident #1) to remain in the facility when there was an allegation of rape made by another resident (Resident #2) and verbally threatened the Social Worker. The findings include: Review of the facility policy titled, "Transfer & Discharge", dated 04/28/10, revealed when a transfer was considered due to a significant change in condition but was not an emergency requiring immediate transfer, an appropriate assessment should be conducted to determine if a new care plan would allow for the resident's needs to be met. Review of the facility policy titled, "Assessing Risk of or Exhibition of Challenging Behaviors", dated 08/31/12, revealed the interdisciplinary team should address resident behaviors in the resident's comprehensive plan of care and care plan interventions should be developed to reduce and eliminate the cause of behavioral symptoms. The interdisciplinary team should rule out potential causes of problematic behavior, which may include relationship difficulties. Assessments for behavioral symptoms and initiation of behavioral interventions should be documented in the medical record and the care plan updated as well as the residents response. Record review revealed the facility readmitted	F 201	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Residents will receive appropriate and timely discharge planning as authorized in the federal and state regulations. Weekly reviews of residents exhibiting challenging behaviors will be conducted in the Interdisciplinary Team meeting. Any identified changes in behaviors will result in proper notifications, and if a discharge notice is required, the notice will be issued 30 days prior to date of discharge or as soon as practicable. The Director of Nursing will review the documented behaviors to ensure that appropriate interventions have been implemented, and the IDT will make recommendations based on the reviews. Monitoring The Director of Nursing Services and / or Medical Records Clerk will review all discharges weekly to ensure that notice of bed hold policy has been provided. The Executive Director will ensure compliance through the QAPI process for 3 months, or until 100% compliance is maintained.	

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F 201	<p>Continued From page 2</p> <p>Resident #1 on 08/08/14 with diagnoses which included Hepatic Encephalopathy, End-stage Renal Disease, Renal Dialysis, Metabolic Encephalopathy, Alcoholic Cirrhosis of the Liver, Diabetes Type II, Anxiety State, Lower Limb Amputation, Depressive Disorder, and Altered Mental Status.</p> <p>Review of a Comprehensive Care Plan, Initiated 02/18/14 and resolved on 03/06/15 revealed, "I sometimes make inappropriate sexual advances towards staff" with a cancelled goal "I will make no inappropriate sexual advances, I will redirect to express myself in appropriate manner as needed". Interventions included, "encourage care in pairs, place me on 1:1 monitoring to help control my behaviors, put me on fifteen minute checks so staff can monitor my behavior, try and redirect as necessary, notify MD if behaviors escalate, anticipate and meet my needs, assist me to develop more appropriate methods of coping and interacting with others."</p> <p>Interview, on 04/23/15 at 5:00 PM with the Social Worker, revealed she had been informed by three (3) or four (4) staff that Resident #1 was having sexual relations with Unsampled Resident A. She stated on 04/13/15, she and the DON spoke with Unsampled Resident #A telling him/her the Ombudsman received word from the State Guardian that it was illegal for a resident (her) to have intimate relations with someone deemed incompetent (Resident #1). The SW stated she informed Resident #1 he/she could not have sexual relations with Unsampled Resident A and he/she accused her of lying; stated he/she was going to "kick my butt"; and, was making threats about her to other staff. The Social Worker revealed the facility's Administrator had taken her</p>	F 201	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The performance Improvement Committee which consists of, but is not limited to, Executive Director, Director of Nursing, Medical Director, Social Services Director, Activity Director, RN Case Manager, RN Assessment Coordinator, Registered Dietician, and Rehab Director.</p>		

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F 201	<p>Continued From page 3</p> <p>off the case at the end of February 2015 and offered for her to work in another office but she chose to keep her office door locked.</p> <p>Further review of the Comprehensive Care Plan revealed there was no revisions to the care plan to address the behavior and no evidence the facility met to determine if a new care plan would allow the facility to meet the resident's needs.</p> <p>Review of the a facility investigation, undated, and Interviews with Certified Nursing Aide (CNA) #1 on 04/21/15 at 9:37 AM, CNA #3 on 04/23/15 at 7:48 PM, and CNA #8 on 04/24/15 at 4:02 PM, revealed Resident #2 alleged on 04/14/15 around midnight or the early morning of 04/15/15 that Resident #1 raped him/her. Further review revealed the facility determined the allegation was unsubstantiated. However, review of Resident #1's Physician's Order Sheet, dated 04/15/15, no time and not signed, revealed a physician's order to send the resident to the local hospital for a behavioral evaluation related to "immediate harm to others and immediate threat". Further review of the physician's orders revealed another order, dated 04/15/15, no time, for "Immediate Discharge from Facility r/t immediate threat to others" written by the Unit Manager (UM) and signed by the physician.</p> <p>Review of the hospital Emergency Room documentation, dated 04/15/15 at 11:05 AM, revealed Resident #1 arrived to the Emergency Room by Emergency Medical Services from the nursing home where staff reported the resident with increased hostility and inappropriate touching. The resident was admitted to the hospital due to laboratory work that determined the resident had a Urinary Tract Infection, and</p>	F 201			

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F 201	<p>Continued From page 4 Hyperammonemia.</p> <p>Interviews, on 04/20/15 at 1:30 PM, 04/23/15 at 11:25 AM and 04/24/15 at 3:25 PM with the State Guardian, revealed the facility had contacted her to obtain consent for Resident #1 to have a sexual relationship with another resident, (Unsampled Resident A). The State Guardian said it was outside of her scope to provide consent for Resident #1 to have an intimate relationship with another resident and was told the facility had since chosen to keep the residents apart. Further interview revealed the State Guardian was notified of Resident #1's discharge on 04/15/15 but she was unsure of the time she was notified. The State Guardian stated the Unit Manager at the facility informed her Resident #1 was discharged to the hospital and there were allegations of abuse from a resident and a staff member against the resident and he/she would be unable to return to the facility.</p> <p>Interview with the Unit Manager (UM), on 04/24/15 at 1:10 PM, revealed Resident #1 was transferred to the hospital due to anger, threatening and agitation in general. She said Resident #1 told the Social Worker he/she was going to blow up the town and facility. The UM said the resident did not make direct threats to any residents. She said she notified Resident #1's physician who wanted the resident sent for a Medical/Psychiatric evaluation. The UM said the resident had no bed hold days available at the facility and there were no plans to readmit Resident #1 and the resident's guardian and the hospital were aware the resident was unable to return to the facility.</p> <p>Interview on 04/21/15 at 8:40 AM, with the</p>	F 201			

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F 201	Continued From page 5 Hospital Discharge Planner, revealed she spoke with the Unit Manager at the facility who said Resident #1 would be unable to return to facility. In addition, the Discharge Planner reported the facility DON suggested the resident be discharged to a Homeless Shelter. Interview, on 04/21/15 at 9:20 AM with the DON, revealed she was notified on 04/15/15 at 7:30 AM of the allegation of abuse made by Resident #2 against Resident #1. The DON said Resident #1 had a history of making sexual remarks and comments in the past and the facility's Social Worker (SW) had tried to arrange a transfer multiple times to a variety of facilities. Review of Resident #1's facility Physician Progress Note, signed by the resident's physician, dated 04/21/15, revealed the physician spoke with the Emergency Room physician, and advised him Resident #1 could not return to the facility. Interview, on 05/08/15 at 9:25 AM with Resident #1's Attending Physician, revealed she was told by someone in an upper level supervisory position from the facility the resident raped another resident and believed it was a safety measure and best for the facility to transfer Resident #1 to the hospital for a psychiatric evaluation. Resident #1's Attending Physician stated the ER physician notified her Resident #1 was admitted to the hospital with a diagnosis related to the resident's lab results.	F 201			
F 203 SS=0	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a	F 203			

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F 203	<p>Continued From page 6</p> <p>resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except as specified in paragraph (a)(5)(II) and (a) (8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone</p>	F 203	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Corrective Action</p> <p>Resident #1 is no longer in the facility, as a involuntary notice of discharge was issued 04/24/15, and has not been appealed. The attending physician and Guardian were notified.</p> <p>Other residents at risk</p> <p>All residents have the potential to be affected when the facility fails to provide notice of discharge as soon as practicable. A review of all residents in the facility for appropriate discharge planning and care plans that reflect discharge potential was completed by the Interdisciplinary team (IDT) on 05/15/15.</p> <p>Systemic Changes</p> <p>Key personnel received education on the notice requirement procedures in order to provide written notice of discharge 30 days prior or as soon as practicable on 04/27/15 by the Executive Director.</p>	5/19/2015	

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F 203	<p>Continued From page 7</p> <p>number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and facility policy review it was determined the facility failed to provide a written notice of transfer/discharge as soon as practicable to the State Guardian for one (1) of five (5) sampled residents (Resident #1) when Resident #1 was transferred to a hospital Emergency Room for a behavioral evaluation for the safety of other individuals in the facility.</p> <p>The findings include:</p> <p>Review of the facility policies titled, "Transfer & Discharge", dated 04/28/10 and "Bed-Hold & Readmission", dated 04/28/11, revealed when a transfer was considered due to a significant change in condition but was not an emergency requiring immediate transfer, an appropriate assessment should be conducted to determine if a new care plan would allow for the resident's needs to be met. At the time of transfer/discharge, the resident and a family member or legal representative should be given a written notice of the bed-hold policy that specifies the duration of the bed-hold and readmission criteria after the bed-hold period ends. Further review revealed when an emergency transfer was</p>	F 203	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Residents exhibiting challenging behaviors will be reviewed weekly in the Interdisciplinary Team meeting to ensure that care plans are updated to include interventions.</p> <p>Monitoring</p> <p>The Director of Nursing Services and / or Medical Records Clerk will review all discharges in order to ensure that notice of bed hold policy has been issued with each discharge. This review will occur weekly until 100% compliance is achieved. The QAPI committee will review findings and the ED and or DNS will ensure that concerns are addressed as needed with education and/ or counseling.</p> <p>The performance Improvement Committee which consists of, but is not limited to, Executive Director, Director of Nursing, Medical Director, Social Services Director, Activity Director, RN Case Manager, RN Assessment Coordinator, Registered Dietician, and Rehab Director.</p>	
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F 203	<p>Continued From page 8</p> <p>Initiated, the notice should be provided to the patient, surrogate, or representative upon transfer, and the bed-hold policy should specify the duration of the bed-hold paid by the pay source. In addition, during the time the patient's bed was on hold, the patient may return to the center and resume residence in the same room and bed; regardless of whether the State pays the Center for a Patient's bed hold. If the applicable State provides bed hold days, during the time the patient's bed is on hold, the patient may return to the Center and resume residence in the same room and bed.</p> <p>Record review revealed the facility readmitted Resident #1 on 08/08/14 with diagnoses which included Hepatic Encephalopathy, End-stage Renal Disease, Renal Dialysis, Metabolic Encephalopathy, Alcoholic Cirrhosis of the Liver, Diabetes Type II, Anxiety State, Lower Limb Amputation, Depressive Disorder, and Altered Mental Status.</p> <p>Review of Physician's Order Sheet, dated 04/15/15, no time indicated, revealed a physician's order, "Immediate Discharge from Facility r/t immediate threat to others" written by the Unit Manager (UM) and signed by the physician.</p> <p>Interviews, on 04/20/15 at 1:30 PM, 04/23/15 at 11:25 AM and 04/24/15 at 3:25 PM with the State Guardian, revealed she was notified of the discharge on 04/15/15 but she was unsure of the time she was notified. The State Guardian stated the Unit Manager at the facility informed her Resident #1 was discharged to the hospital and there were allegations of abuse from a resident and a staff member against the resident and</p>	F 203			

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F 203	Continued From page 9 he/she would be unable to return to the facility; however, she had not received a written transfer/discharge notice. Interview on 05/08/15 at 8:50 AM with the facility's Social Worker, revealed the facility Administrator was responsible for providing a written transfer/discharge notice to the guardian. Interview, on 04/24/15 at 12:28 PM with the facility Administrator, revealed she was on vacation 04/13/15 through 04/17/15. She said the facility had not discharged or issued a transfer/discharge notice to the State Guardian. A Post Survey Interview, on 05/08/15 at 12:00 PM with the facility Administrator, revealed she was responsible for issuing discharge letters to the resident, guardian and attending medical doctor whenever a resident was discharged. The facility Administrator said Resident #1 was discharged since he/she had exhausted bed hold days. The Administrator said she issued a formal discharge notice by certified mail to Resident #1's guardian, the resident and the attending Physician on 04/24/15.	F 203			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225			

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F 225	<p>Continued From page 10</p> <p>other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Abuse and Neglect Policy and facility's investigation, it was determined the facility failed to ensure staff reported an allegation of rape immediately to the Administrator and failed to assess non-interviewable residents for signs and symptoms of abuse during the investigation of alleged abuse for one (1) of five (5) sampled residents (Resident #2).</p>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Corrective Action</p> <p>Resident #1 is no longer in the facility, as a involuntary notice of discharge was issued 04/24/15, and has not been appealed. Prior to his/ her discharge from the facility, Resident #1 was placed on increased supervision. Q 15 minute checks were in place, and then on 04/15/15, Resident #1 was placed on 1:1 supervision until his/ her discharge to an acute hospital setting. LPN #3 was suspended by the Director of Nursing on 04/15/15. Prior to returning to work, LPN #3 was counseled and provided education regarding the facility policy and procedure for reporting abuse immediately by the RN Staff Development Coordinator 04/15/15.</p> <p>Other residents at risk</p> <p>Resident #2 had a skin assessment completed by the RN Assessment Coordinator on 04/15/15. Law Enforcement, family, and physician were notified and Resident #2 sent to JPMC for Emergency Room evaluation and treatment.</p>	5/19/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2015
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42086		
(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 11</p> <p>On 04/15/15, Resident #2 alleged he/she was raped and staff did not report the allegation until the end of the shift which was approximately five (5) hours later. Resident #2 was transferred to the local hospital for evaluation. During the facility's investigation, non-interviewable residents were not assessed for sign/symptoms of abuse.</p> <p>The findings include:</p> <p>Review of the facility's Abuse and Neglect Policy, dated 07/28/14, revealed all alleged violations involving mistreatment, neglect or abuse are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The center must report all alleged violations involving mistreatment, neglect, or abuse immediately to a Senior Clinician, or Operational Leader at the facility, or District, or National Level. Review of the facility's policy titled "Investigation", dated 2008, revealed the allegation would be investigated and the investigation would specify the type of allegation, details of incident, description of any injuries, document any treatment rendered, list of known and possible witnesses, staff interviews, and interview with alleged victim and alleged perpetrator.</p> <p>Record review revealed the facility readmitted Resident #2 on 03/13/15 with diagnoses which included Dementia, Chronic Kidney Disease, Depression, and Deafness. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/19/15, revealed the facility assessed the resident as severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of nine-nine (99), indicating the resident was non-interviewable.</p>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Upon evaluation it was determined that there was no evidence to support abuse.</p> <p>Video surveillance from 04/15/15 was reviewed by the Executive Director on 4/20/15. Resident #1 was observed at the nurses' station during the shift. Video revealed that he/she did not ambulate in other areas of the facility.</p> <p>Resident with BIMS of 8 and higher were interviewed by the Social Services Director and asked "Have you ever had any trouble with a male resident being physically or verbally aggressive with you, and Have you ever seen a male resident being physically or verbally abusive with another resident?" All responded "No". Behavior logs were reviewed for any psychosocial changes related to the alleged incident.</p> <p>Systemic Changes</p> <p>Education regarding the facility policy related to reporting abuse immediately was initiated with staff members on 04/15/15 by the RN Staff Development Coordinator. Licensed Staff education included the</p>		

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F 225	<p>Continued From page 12</p> <p>Review of the facility's investigation, undated, revealed Resident #2 alleged someone raped him/her on 04/14/15. Further review of the investigation revealed residents with BIMS score of eight (8) or greater were interviewed; however, there was no documented evidence the facility assessed non-interviewable residents (BIMS score less than eight) to determine if they had any signs/symptoms of abuse. Review of Resident #2's Nursing Notes, revealed the alleged incident was charted on 04/15/15 at 1:37 AM; however, there was no documentation of a skin assessment or notification of the Director of Nursing (DON) or Administrator on night shift.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 04/21/15 at 9:37 AM, revealed Resident #2 had nights when he/she would stay awake all night. CNA #1 stated around midnight on 04/14/15, Resident #2 stated to her, "He tried to get in bed with me and I am not that kind of girl" and then repeated this information to two (2) or three (3) nurses at the nursing station. CNA #1 stated she wrote down exactly what Resident #2 had said to her and Resident #2 did not say who "HE" was.</p> <p>Interview, on 04/23/14 at 7:48 PM with CNA #3, revealed around 12:30 AM to 1:00 AM on 04/15/15 she and CNA #8 were putting Resident #2 to bed and the resident pointed to his/her private area and stated, "He raped me". CNA #3 stated she asked the resident to repeat what she had said and the resident kept saying "I don't want to be in here because he tried to get me in the bed." CNA #3 revealed Resident #2 would not say who "he" was but had pointed to Resident #1's room when talking about the alleged incident. CNA #3 revealed she reported the</p>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>importance of completing skin assessments on all non interviewable residents in the event of an allegation. Reviewing residents for signs of abuse such as bruising, reddened areas, in addition to observing for non verbal signs of distress were a part of the education as well. A post education questionnaire was administered to staff following the training which included identifying the different types of abuse (see attachment).</p> <p>This was completed by the RN Staff Development Coordinator on 04/27/15.</p> <p>Monitoring</p> <p>Random interviews will be conducted by the Executive Director and / or The Director of Nursing Services with a resident from each of the four halls 3 times weekly for one month, then two times weekly for one month, and then once weekly until compliance is maintained. Resident Council members will be interviewed monthly by the Activity Director during the regular meeting, with any concerns reported and addressed immediately.</p>		

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F 225	<p>Continued From page 13</p> <p>allegation to LPN #3, and wrote a statement of what happened and signed it.</p> <p>Interview, on 04/24/15 at 4:02 PM with CNA #8, revealed Resident #2 was sitting at the nursing station when she came on shift around 10:30 PM on 04/14/15, then was sitting in front of Resident #1's door around 11:00 PM-11:30 PM. CNA #6 stated Resident #2 pointed to Resident #1's door and stated, "I hate him, I hate him", he is a bad man". CNA #8 revealed she corrected the resident on talking about another resident that way and Resident #2 got mad. CNA #8 revealed around 1:00-2:00 AM when Resident #2 was assisted to the bathroom, the resident stated, "he tried to rape me and I told him I'm not that kind of girl." CNA #6 stated her and CNA #3 reported the allegation to the nurses and left it up to them to report to administration.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/20/15 at 3:11 PM, revealed she heard the CNA #3 and #6 report to LPN #3 around midnight to 1:30 AM on 04/15/15 that Resident #2 stated "He tried to rape me". LPN #1 stated when she heard the CNAs report the allegation to LPN #3, she told them to write down what the resident had said. LPN #1 said LPN #3 passed the information of the alleged rape incident along in shift report to day shift.</p> <p>Interview on 04/21/15 at 8:32 PM with LPN #3 revealed CNA'S #1, #3 and #6 told her on 04/15/15 around midnight to 1:30 AM Resident #2 stated "he raped me" but Resident #2 did not reveal who "he" was and she told the CNAs to write down what Resident #2 said to them, then date it and sign it and she would take it from there. LPN #3 stated Resident #2 had told the</p>	F 226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>The Executive Director and / or DNS will review all allegations to ensure that skin assessments have been completed timely for non interviewable residents. This will be ongoing until 100% compliance is maintained. Any identified concerns will be reviewed immediately by the ED/DNS and the QAPI team will review results of interviews and assessments monthly until compliance is maintained.</p> <p>The Performance Improvement Committee which consists of, but is not limited to, Executive Director, Director of Nursing, Medical Director, Social Services Director, Activity Director, RN Case Manager, RN Assessment Coordinator, Registered Dietician and Rehab Director. The committee will review concerns from the IDT to ensure that all discharges have occurred following facility protocol. Any issues will be addressed with education and or counseling.</p>		

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F 225	Continued From page 14 CNA'S he/she had been raped. LPN #3 revealed Resident #2 was a wanderer and had to be taken out of other resident's rooms a lot. LPN #3 stated Resident #1 was already on watch for sexually inappropriate behaviors with another resident. LPN #3 further revealed no one goes into Resident #1's room by themselves, due to his/her sexual behaviors. LPN #3 stated she thought she had twenty-four (24) hours in which to report an alleged incident of abuse to Administration. LPN #3 further revealed she charted in the hallway the rest of the night, so she could keep a closer watch on Resident #2. Interview on 04/24/15 at 12:37 PM with Administrator revealed she was on vacation from 04/13/15- 04/17/15 and not in the building when the alleged incident with Resident #2 occurred. She stated this incident was investigated by the Director of Nursing (DON). Interview, on 04/21/15 at 9:20 AM with the Director of Nursing (DON), revealed she was made aware of Resident #2's allegation of rape on 04/15/15 at 7:30 AM by the Registered Nurse (RN) on day shift. The DON stated LPN #3 had told the day shift RN about the allegation in shift report that morning and reported the alleged rape was supposed to have occurred around 11:30 PM-1:30 AM. The DON stated the facility policy was to report allegations of abuse/neglect immediately. She stated the Social Service Director was responsible for the investigation and interviews and the nurses were responsible for completing the skin assessments.	F 226			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226			

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F 228	<p>Continued From page 15</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Abuse and Neglect Policy and facility investigation, it was determined the facility failed to ensure one (1) of five (5) sampled residents (Resident #2) allegation of abuse was reported immediately to the Administrator and was investigated to include skin assessments of non-interviewable residents for signs and symptoms of abuse per the facility's policy. Refer to F225</p> <p>The findings include:</p> <p>Review of the facility's Abuse and Neglect Policy, dated 07/28/14, revealed the facility staff would report allegations of abuse/neglect immediately to the Administrator of the facility. Review of the facility's policy titled "Investigation", dated 2006, revealed the allegation would be investigated and the investigation would specify the type of allegation, details of incident, description of any injuries, document any treatment rendered, list of known and possible witnesses, staff interviews, and interview with alleged victim and alleged perpetrator.</p> <p>1. Review of the facility's investigation, undated, and interviews with Certified Nursing Aide (CNA) #1 on 04/21/15 at 9:37 AM, CNA #3 on 04/23/15 at 7:48 PM, and CNA #8 on 04/24/15 at 4:02 PM,</p>	F 228	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Corrective Action</p> <p>Resident #1 is no longer in the facility, as a involuntary notice of discharge was issued 04/24/15, and has not been appealed. Prior to his/ her discharge from the facility, Resident #1 was placed on increased supervision. Q 15 minute checks were in place, and then on 04/15/15, Resident #1 was placed on 1:1 supervision until his/ her discharge to an acute hospital setting.</p> <p>LPN #3 was suspended by the Director of Nursing on 04/15/15. Prior to returning to work, LPN #3 was counseled and provided education regarding the facility policy and procedure for reporting abuse immediately by the RN Staff Development Coordinator 04/15/15.</p> <p>Other residents at risk</p> <p>Resident #2 had a skin assessment completed by the RN Assessment Coordinator on 04/15/15. Law Enforcement, family, and physician were notified and Resident #2 sent to JPMC for Emergency Room evaluation and treatment.</p>	5/19/15
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F 226	<p>Continued From page 16</p> <p>revealed Resident #2 alleged on 04/14/14 around midnight or early morning of 04/15/15 that Resident #1 raped him/her. CNAs #3 and #8 reported the allegation to LPN #3.</p> <p>Interviews with Licensed Practical Nurse (LPN) #1 on 04/20/15 at 3:11 PM, LPN #2 on 04/20/15 at 3:52 PM, and LPN #3 on 04/21/15 at 8:32 PM, revealed CNAs #3 and #8 reported Resident #2's allegation of rape to them around midnight or 1:30 AM on 04/14/15-04/15/15; however, they did not notify the Administrator or Director of Nursing at that time. LPN #3 reported the allegation to the oncoming nurse the next morning at 8:00 AM during shift report which was approximately five hours after the allegation instead of to the Administrator immediately per the facility's policy.</p> <p>Further review of the facility's investigation, undated; and review of a Nursing Note, dated 04/15/15 at 1:37 AM revealed there was no documented evidence skin assessments were conducted with non-interviewable residents (BIMS score of seven [7] and below) to determine if there were any signs and symptoms of abuse to ensure a complete investigation was conducted per facility policy.</p> <p>Interview, on 04/21/15 at 9:20 AM with the Director of Nursing (DON), revealed she was made aware of Resident #2's allegation of rape on 04/15/15 at 7:30 AM by the Registered Nurse (RN) on day shift. The DON stated LPN #3 had told the day shift RN about the allegation in shift report that morning and reported the alleged rape was supposed to have occurred around 11:30 PM-1:30 AM. The DON stated the facility policy is to report allegations of abuse/neglect immediately. She stated the Social Service</p>	F 226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Upon evaluation it was determined that there was no evidence to support abuse.</p> <p>Video surveillance from 04/15/15 was reviewed by the Executive Director on 4/20/15. Resident #1 was observed at the nurses' station during the shift. Video revealed that he/she did not ambulate in other areas of the facility.</p> <p>Resident with BIMS of 8 and higher were interviewed by the Social Services Director and asked "Have you ever had any trouble with a male resident being physically or verbally aggressive with you, and Have you ever seen a male resident being physically or verbally abusive with another resident?" All responded "No". Behavior logs were reviewed for any psychosocial changes related to the alleged incident.</p> <p>Systemic Changes</p> <p>Education regarding the facility policy related to reporting abuse immediately was initiated with staff members on 04/15/15 by the RN Staff Development Coordinator. Licensed Staff education included the</p>		

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F 226	Continued From page 17 Director was responsible for the investigation and interviews and the nurses were responsible for completing the skin assessments.	F 226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>importance of completing skin assessments on all non interviewable residents in the event of an allegation. Reviewing residents for signs of abuse such as bruising, reddened areas, in addition to observing for non verbal signs of distress were a part of the education as well. A post education questionnaire was administered to staff following the training which included identifying the different types of abuse (see attachment).</p> <p>This was completed by the RN Staff Development Coordinator on 04/27/15.</p> <p>Monitoring</p> <p>Random interviews will be conducted by the Executive Director and / or The Director of Nursing Services with a resident from each of the four halls 3 times weekly for one month, then two times weekly for one month, and then once weekly until compliance is maintained. Resident Council members will be interviewed monthly by the Activity Director during the regular meeting, with any concerns reported and addressed immediately.</p>		