

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185694	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 280 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 226	<p>Continued From page 54 questionnaires.</p> <p>Review of the HR Audits of personnel files revealed the CNE validated review by signature on the back of the audit forms. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed there were no issues identified with the review of the employee files.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed a corporate staff member had been at the facility since the jeopardy was identified and had been reviewing all allegations to ensure a thorough investigation was conducted. Further interview revealed the corporate staff was also conducting chart audits, observed staff treatment of residents, and provided consultation.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed all facility grievances filed since 04/01/14 were reviewed for possible allegations of abuse/neglect. The interview revealed one grievance was related to cigarettes that were missing. The incident was investigated with no concerns identified. Continued interview revealed the facility's smoking policy had recently been updated to account for all residents' cigarettes.</p> <p>Interviews on 06/04/14 with the Regional Nurse Consultant and SDC revealed a Resident Council meeting was held on 05/30/14 to discuss abuse/neglect concerns and education was provided on reporting abuse/neglect concerns without fear of retribution. The interview further revealed residents that did not attend the meeting were also provided education related to reporting abuse.</p>	F 228			

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F 228	Continued From page 55 Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed as of 05/29/14 a daily census was completed and residents were chosen by the Administrator to be interviewed and to observe staff as they provided care to the resident which was done by Administrative Staff. The interview further revealed staff providing care to residents with a BIMS score less than 8 were interviewed about changes in the resident. The Administrator or a member of the regional team validated the interviews and observations of care were completed. Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed a binder with all questionnaires related to abuse/neglect was passed to each Department Head assigned to distribute the questionnaires. The interview further revealed the staff had notified the Administrator with the results of the questionnaires. A review of the binder revealed no issues were identified. The binder contained a resident roster which included the dates and shifts the residents had been interviewed or assessed. The binder had been updated as BIMS scores changed. There were no issues identified during the interviews. Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed the Administrator or regional team member had reviewed all questionnaires with no issues identified. A review of the questionnaires revealed a signature validated the questionnaires had been reviewed. Interview with Administrative Nursing Staff on	F 226			

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F 226	<p>Continued From page 56</p> <p>06/04/14 revealed resident charts had been reviewed each day for entries in the Nurse's Notes that could be related to abuse or neglect.</p> <p>Interview on 06/04/14 with Administrative Nursing Staff revealed all resident charts had been audited from 04/01/14 for any documentation regarding abuse and no new concerns were identified. The interviews revealed ten charts continued to be reviewed daily for any new documented evidence of abuse that was not reported.</p> <p>Interview on 06/04/14 with Administrative Staff and the Regional Nurse Consultant revealed all abuse investigations had been discussed and reviewed daily to ensure the facility's abuse policy was followed to ensure the resident was protected, the perpetrator was removed from the resident care area, the incident was reported timely, and an investigation was completed. Further interview revealed the Administrator maintained an abuse log to ensure all areas of the investigations were completed. Continued interviews revealed the Administrator and one corporate staff member reviewed investigations to ensure they were complete.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed after the Immediate Jeopardy was removed new reports of alleged abuse investigations will be reviewed by a Corporate Staff Member prior to the five-day report being sent to OIG. The Corporate Staff member will ensure the resident was protected, the incident was reported timely, the perpetrator was removed from patient care area, and a thorough investigation was completed.</p>	F 226			

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F 226	<p>Continued From page 57</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed new reports of abuse or neglect will be reported to a Corporate Staff Member within 24 hours to ensure an investigation was completed and the reporting timelines were met.</p> <p>Interviews on 06/04/14 with Administrative Nursing Staff and the Regional Nurse Consultant revealed all incident reports that had been completed since January 2014 were reviewed for concerns related to abuse/neglect and none were identified.</p> <p>Interview on 06/04/14 with the MDS Coordinator revealed questions about concerns related to abuse/neglect and education about reporting abuse/neglect were added to the care plan conferences. The interview further revealed resident family members that attended the care plan conferences were questioned about abuse/neglect concerns in the facility and educated on how to report an abuse/neglect concern.</p> <p>Interviews on 06/04/14 with the Administrator and the Regional Nurse Consultant revealed administrative oversight was completed weekly and will continue monthly after the Immediate Jeopardy was removed.</p> <p>Interviews on 06/04/14 with the DON, ADON, and SDC revealed observation of staff as they provided care was completed for any suspected abuse/neglect concerns on a daily basis for five residents and will continue weekly after the removal of the Immediate Jeopardy. Continued interviews revealed the reports were reported to the QA Committee to determine the need for</p>	F 226			

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F 226	Continued From page 58 additional education concerns or change of the plan. Interviews on 06/04/14 with Administrative Staff revealed a Quality Assurance meeting had been held weekly beginning 05/29/14 and will be held weekly for four weeks and then monthly. The interviews further revealed evaluations by the Committee would determine the frequency and length of ongoing audits. Further interviews revealed corporate oversight had been in place since 05/29/14, on a daily basis, until the immediate Jeopardy was removed and will continue weekly for four weeks and then will continue monthly.	F 226			
F 490 SS-J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, review of the facility's Abuse, Neglect and Misappropriation policy, dated April 2013, and review of the job description for the Administrator, it was determined the Administrator failed to administer the facility in a manner to ensure its resources, including policies related to abuse and neglect, were implemented to maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of	F 490	F-490 1. The allegation of abuse reported by residents # 32 and 35 were reported to the Office of Inspector General by 5/29/14 by the Director of Nursing and reported to APS, Ombudsman, MD and POA by 5/30/14 by the Director of Nursing, ADDN or charge nurse. Resident # 32 and 35 have been physically assessed by a nurse and psychosocially assessed by the social services director by 5/30/14. Resident # 32 and 35 were interviewed and statement obtained by the house supervisor, director of nursing or social services director by 5/30/14. Alleged perpetrator for resident # 32 was suspended pending outcome of thorough investigation and alleged perpetrator for resident #35 is no longer employed by the facility. Thorough investigation initiated on residents #32, and 35 by 5/30/14 by the DON, ADDNs, Social services director or regional nurse consultant. All residents have been assessed for any signs and symptoms of abuse/neglect. Those residents with BIMs > 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 5/29/14. Those residents with BIMs < 8 were physically assessed by the ADDNs for any signs and symptoms of abuse/neglect along with all resident POA's contacted by social services director or chaplain to question any abuse/neglect concerns by 6/1/14. 2. An audit of all personnel records, to include any counseling, coaching, suspension and/or termination forms, was completed by the Human Resources Director and results reviewed by the Chief Nursing Executive by 5/30/14, to ensure compliance with federal and state regulations related to reporting any suspected abuse/neglect allegations and the employment of staff.	6/30/14	

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F 490	<p>Continued From page 59</p> <p>three (3) sampled residents (Residents #32 and #35). Interviews and review of witness statements revealed on 06/24/14 Resident #35 reported that State Registered Nurse Aide (SRNA) #3 talked mean to him/her when the resident had requested a cold, wet washcloth. Even though the facility identified the alleged perpetrator in the incident related to Resident #35 as State Registered Nurse Aide (SRNA) #3, the facility failed to protect the residents as per facility policy which indicated, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..."</p> <p>In addition, review of incident reports and interviews revealed on 05/25/14 staff observed bruising to Resident #32's arm and the resident alleged "fat Pat grabbed" his/her arm. The facility identified the alleged perpetrator as SRNA #2. Interviews revealed SRNA #2 was suspended on 05/25/14 while the Director of Nursing (DON) investigated the incident. Although the facility had not assessed or interviewed other residents for signs of abuse, and had not interviewed staff related to care delivered by the alleged perpetrator to facility residents, the SRNA was allowed to return to work to provide direct resident care on 05/28/14. The DON stated she hadn't felt "like it was an allegation of abuse" because the resident reported different stories about the incident.</p> <p>Interview and record review revealed the facility's Administration failed to ensure allegations of abuse and neglect were reported immediately to appropriate State Agencies; and failed to ensure</p>	F 490	<p>A review of all grievances and accidents/incidents from January 2014 to May 2014 was completed by DON, ADONs' SDC, MDS, by 5/30/14 to ensure all have been thoroughly investigated along with any suspected abuse/neglect identified was reported in accordance with state/federal law to ensure reporting guidelines have been met. 1 allegation was identified, reported in accordance with state/federal guidelines and thorough investigation completed.</p> <p>All residents were assessed for any suspected and/or allegations of abuse/neglect. Residents with BIMs score of > 8 were interviewed by the Social services director or chaplain by 5/30/14 for any suspected neglect issues and Residents with BIMs score of < 8 were assessed by DON, ADONs, FFN, or SDC by 5/30/14 for any s/s of suspected neglect along with residents POA's were contacted and questioned by social services director or chaplain by 5/30/14 for any suspected abuse/neglect concerns. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator, Regional Nurse Consultant or the Chief Nurse Executive by 5/30/14 for any indications of abuse/neglect concerns.</p> <p>Chart audits to include review of nurses notes, dietary notes, social services notes, quality of life notes and interdisciplinary notes were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or Regional Nurse Consultant by 5/30/14 for all residents to identify any suspected abuse/neglect allegations that have not been reported.</p> <p>3. The facility department managers, to include, administrator, DON, ADONs, SDC, MDS, wound</p>		

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F 490	<p>Continued From page 60</p> <p>residents were protected from potential abuse while an investigation of the alleged abuse was conducted. In addition, the facility's Administration failed to ensure the facility's investigation included resident and staff interviews and assessment of other residents for signs of abuse and neglect. (Refer to F225 and 226.) The facility's policy revealed, "...remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation...The Administrator and/or DON will notify state agencies according to their reporting guidelines..." Section II, "Training/Identification/Prevention," of the facility policy revealed staff is trained to identify "...Signs & Symptoms of abuse (bruises, injuries of unknown origin, crying, fearful, increased agitation, and withdrawal)..." as part of their orientation.</p> <p>In addition, review of the job description for the facility's Administrator revealed the Administrator would "lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives."</p> <p>The Administration's failure to ensure the facility's policies/procedures related to abuse prevention were implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents at the facility. Immediate Jeopardy was determined to exist on 05/24/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 483.75 Administration (F490 and F520) with Substandard Quality of</p>	F 490	<p>care nurse, BOM, QOL, maintenance director, Housekeeping director, DM, Marketing/Admissions, SSD, RSM, FFM MR and Chaplain received education from the Regional Nurse Consultant on 5/29/14 regarding the abuse/neglect policy and procedure which included - appropriately identifying any suspected abuse/neglect allegations, appropriate reporting in accordance with state/federal guidelines, ensuring safety of the residents, and conducting a thorough investigation along with the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and question and include examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident to resident altercations to include verbal or physical, and taking belongings or exploitation. Post-test was administered and 100% score obtained, if manager did not score 100% on post-test, then manager will be immediately re-educated and post-test re-administered. This process will continue until manager obtains a 100% score on post-test.</p> <p>Once the facility Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFM were re-educated on the abuse policy they were then assigned to re-educate the staff on the abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements, which started on 5/29/14. No employee will be allowed to work until abuse</p>		

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F 490	<p>Continued From page 61</p> <p>Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). The facility was notified of the Immediate Jeopardy on 05/29/14.</p> <p>An acceptable Allegation of Compliance was received on 06/02/14 which alleged removal of the Immediate Jeopardy on 05/31/14. A partial extended survey was conducted on 06/03/14 and 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14 as alleged, which lowered the Scope and Severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F225, F226, and F520.)</p> <p>The findings include:</p> <p>The facility's policy entitled "Abuse, Neglect and Misappropriation," revised March 2013, revealed "...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines..." In addition, the policy revealed, "...The charge nurse will immediately remove the suspected perpetrator from resident care areas; obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..." The policy revealed, "...The charge nurse will immediately notify the Administrator, DON and/or Abuse Coordinator as appropriate...The Administrator and/or DON will</p>	F 490	<p>education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. Education regarding the abuse policy and procedure, to include identification/reporting and the Quality Assurance Performance Improvement process will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until abuse education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test.</p> <p>Staff questionnaire regarding abuse, to include the question, "What would you do if a resident told you that you were mean to them", is being administered by Administrator, DON, ADDNs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN to 10 different staff members daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating and reporting of abuse/neglect, and the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and fine staff participation in development of QAPI plan. Results of the staff questionnaire will be reported to the QA committee weekly for 4 weeks, starting on 5/29/14, to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will</p>		

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F 490	<p>Continued From page 62</p> <p>notify state agencies according to their reporting guidelines..." In addition, according to the policy, "...All allegations of abuse will be investigated and reported to the appropriate agencies...The Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances..."</p> <p>According to section II, "Training/Identification/Prevention," of the facility policy, staff is trained to identify "...Signs & Symptoms of abuse (bruises, injuries of unknown origin, crying, fearful, increased agitation, and withdrawal)..." as part of their orientation.</p> <p>Review of the facility's "Job Description" for "Administrator," dated December 2011, revealed the Administrator would "lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives."</p> <p>Review of an incident report dated 05/25/14, revealed facility staff observed bruising to Resident #32's wrist/forearm area on 05/25/14 at 4:00 AM. Further review of the incident report revealed the resident stated, "Fat Pat grabbed my arm and wouldn't let go; I had to pull myself loose." Interview conducted with Licensed Practical Nurse (LPN) #1 on 05/29/14 at 11:53 AM revealed she had assessed Resident #32 when the bruises were identified on 05/25/14, and had immediately notified the DON.</p> <p>Interview with the Administrator on 05/29/14 at 6:17 PM revealed staff had notified him on 05/25/14 of the bruises to Resident #32's arm</p>	F 490	<p>determine at what frequency the staff questionnaire will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected Abuse/neglect was thoroughly investigated and completed along reporting guidelines are met.</p> <p>Hand in Hand training, module one, was initiated on 5/13/14 by SDC and completed on 6/4/14. There is an education calendar in which all modules have been scheduled to include all 6 modules over the next 6 months. Make up sessions will be offered until all employees have attended. New employees in orientation will receive the Hand in Hand training on a set schedule to ensure all 6 modules are completed.</p> <p>The Administrator, DON, ADDNs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN, will be on site daily for 4 weeks to perform walking rounds in which 10 residents (five with BIMs >8 and five with BIMs <8) will be visited by the department head and interviewed regarding staff treatment for those residents that can be interviewed and for those residents who are not able to be interviewed the department heads will visit the resident, skin check will be completed by nurse as well as speak to nurse and C.N.A. regarding any noted changes in resident behaviors. The facility department heads also will interview 10 different staff members daily regarding the types of abuse, who is the abuse coordinator, when is suspected abuse reported, what would you do if a resident told you that you were mean to them etc. which began on 5/29/14. Results of resident and staff</p>		

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F 480	<p>Continued From page 63 and forearm. The facility determined the alleged perpetrator was identified as SRNA #2. Further interviews revealed the SRNA was suspended on 05/25/14 while the DON investigated the incident. The Administrator further stated the facility had not assessed or interviewed other residents for signs of abuse, and staff had not been interviewed related to care delivered by the alleged perpetrator to facility residents. However, the facility's policy stated, "...All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through established guidelines...The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation..."</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 06/02/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>-The allegation of abuse reported by Resident #32 was reported to the Office of Inspector General (OIG) on 05/27/14 by the DON. Resident #32 has a BIMS score greater than 8 and a statement was obtained on 05/25/14. The alleged perpetrator was suspended on 05/25/14. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 06/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director, or Chaplain for any abuse/neglect concerns on</p>	F 490	<p>questionnaire's will be reported to the Administrator, DON, Regional Nurse Consultant or VP of Operations daily and if the Administrator is not in the facility the Department Director conducting the questionnaires will telephone the Administrator or VP of Operations the results of the resident and staff questionnaires.</p> <p>The Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN will notify Administrator of any concerns immediately regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect or misappropriation, ensuring resident is safe. A binder, which is passed on to each Department Head assigned to perform the resident and staff questionnaires daily, which contains a resident roster in which the interview date and shift is noted next to resident name to ensure that residents with BIMS >8 will be interviewed and residents with BIMS <8 will be visited, with skin checks completed, beginning on 5/29/14. The MDS Coordinators have the responsibility for updating the binder weekly to identify residents with BIMS >8 and residents with BIMS <8. If abuse, mistreatment, neglect or misappropriation is alleged during the interviews and or visits or reported by a staff member the Department Head will ensure the resident is safe, report to a charge nurse in which the charge nurse will remove the alleged perpetrator to a non-patient care area and notify the Administrator, Director of Nursing, and/or Social Services Direct/Abuse Coordinator. The alleged perpetrator will be suspended and a thorough investigation will begin immediately.</p>		

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2014
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F 490	<p>Continued From page 64</p> <p>05/29/14. On 05/29/14, the Assistant Directors of Nursing (ADONs) assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 Power of Attorneys (POAs) for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted.</p> <p>—The allegation of abuse related to Resident #33 that occurred on 05/24/14 was reported to OIG on 05/29/14 by the DON and reported to Adult Protective Services (APS), the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. A facility nurse assessed Resident #33 on 05/29/14 and the resident had a psychosocial assessment completed by the Social Services Director on 05/30/14. Resident #33 was interviewed and a statement was obtained by the facility's Social Services Director on 05/30/14. The alleged perpetrator was no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with a BIMS score less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to</p>	F 490	<p>The Administrator, Director of Nursing, Social Services or a member of regional staff will review all resident and staff questionnaires daily for any grievances/concerns and/or suspected allegations of abuse/neglect. Any suspected allegations of abuse/neglect will be immediately reported in accordance with state/federal guidelines and thorough investigations of any suspected allegations of abuse/neglect along with any grievances/concerns will be initiated upon receipt, starting on 5/30/14.</p> <p>During care plan conference for each resident any potential allegation of abuse/neglect will be discussed and education will be provided on whom to report abuse/neglect concerns by the MDS coordinator.</p> <p>The Administrator, Social Services Director or the Director of Nursing will review, daily, the grievances and incident/accident reports, starting 5/29/14, to determine if there are reportable allegations that have not been identified. Social Services Director or the Director of Nursing will report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect or misappropriation in accordance with state/federal guidelines to meet reporting requirements.</p> <p>An emergency resident council meeting was held on 5/30/14, Administrator and SDC attended, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. All residents with BIMS < 8 POA's were attempted to be contacted by Social Services Director to discuss any abuse/neglect concerns and to provide</p>		

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

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F 490	<p>Continued From page 65</p> <p>abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>—The allegation of abuse reported by Resident #35 was reported to the Office of Inspector General on 05/29/14 by the DON and reported to APS, the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. Resident #35 was physically assessed by a nurse and psychosocially assessed by the Social Services Director on 05/30/14. Resident #35 was interviewed and a statement was obtained by the Social Services Director on 05/30/14. The alleged perpetrator is no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p> <p>—All residents were assessed for any signs and symptoms of abuse/neglect. Those residents</p>	F 490	<p>education on whom to report any abuse/neglect concerns without fear of retribution on 5/30/14.</p> <p>Nursing Administration (DON, ADON, Unit Manager, Staff Development Coordinator, MDS staff, facility formulary nurse, medical records, or social service director) will review documentation in the chart in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on 5 residents starting on 6/5/14. Any of the above concerns identified, the member of Nursing Administration will first ensure resident is safe by performing an assessment, notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area (if on duty) and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>Administrator will keep an abuse investigation log that will include documentation of the following: ensure resident is protected, report is filed timely, perpetrator is removed from patient care area and thorough investigation is completed. The Administrator will review the log daily as well as one of the following: Signature Care Consultant, VP of Operations, or Special Projects Administrator along with Chief Operating Officer or Chief Nursing Executive will review log for compliance weekly, starting on 6/5/14 for 4 weeks, then monthly.</p> <p>In the event of any new reports of alleged abuse, neglect or misappropriation of property, one of the following will be contacted within 24 hours and then again prior to making the final five day investigation report to OIG: Signature Care</p>		

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

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F 490	<p>Continued From page 66</p> <p>with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 28; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted. The Administrator, the Regional Nurse Consultant, and the Chief Nurse Executive reviewed abuse/neglect audits, assessments, interviews, and questionnaires on 05/30/14 for any indications of abuse/neglect concerns.</p> <p>--The facility's Regional Nurse Consultant from the corporate office re-educated the facility Administrator, the DON, the ADONs, the Minimum Data Set (MDS) Coordinator, the Staff Development Coordinator (SDC), the Director of Dining Services, the Business Office Manager, the Social Services Director, the Activities Director, the Chaplain, Marketing/Admissions, Medical Records, Human Resources, and Wound Care staff on 05/29/14 on the facility's abuse policy and procedure. The education included but was not limited to thorough investigations, reporting immediately, and the Quality Assurance Performance Improvement (QAPI) process, including reporting of concerns to the Administrator and floor staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and questions and included examples</p>	F 490	<p>Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator or Chief Nursing Executive) will insure the resident is protected, report is filed timely, the perpetrator is removed from the patient care area and a thorough investigation is initiated and completed.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive or Chief Operating Officer weekly starting 6/5/14 for 4 weeks, then monthly.</p> <p>DON, ADONs, or SDC will observe the care delivery, for any suspected abuse/neglect concerns on 1 resident/unit daily (Monday through Friday) starting on 6/5/14 for 4 weeks. Any concerns noted the nursing administration will first ensure resident is safe by performing an assessment and notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>4. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive, or Chief Operating Officer, weekly for 4 weeks beginning 6/5/14, then monthly.</p>		

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

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F 490	<p>Continued From page 67</p> <p>of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident-to-resident altercations to include verbal or physical, and taking belongings or exploitation. Department administrative managers were not allowed to return to work until abuse education was provided, post-tests administered, and a score of 100% obtained. If the manager did not score 100% on post-test, then the manager was immediately re-educated and re-tested. This process continued until all managers obtained a 100% score on the post-test. All post-tests were reviewed for compliance by the Chief Nursing Executive (CNE).</p> <p>-After the facility Administrator, DON, ADONs, Minimum Data Set (MDS) Coordinator, Staff Development Coordinator (SDC), Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions staff, Medical Records staff or Director, Human Relations (HR) staff, or Wound Care staff were re-educated on the abuse policy, the Administrative staff was assigned to re-educate the staff on the abuse policy and procedure which included but was not limited to reporting, protection, and investigation requirements, which started on 05/29/14. The facility did not allow any employee to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and the post-test re-administered. This process continued until all employees obtained a 100% score on the post-test. Education regarding the abuse policy and procedure, including identification/reporting and the Quality Assurance</p>	F 490	<p>The Administrator or Signature Care Consultant will audit compliance of the above stated audits/reviews daily (M-F). Results of the audits/reviews, which include, resident interviews, resident skin checks, staff questionnaires, grievance log review, A/I review, chart documentation audits and care delivery audits will be reported to the QA committee weekly x 4 weeks to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits/reviews, along with monitoring for compliance, will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected neglect was investigated and completed along with reporting guidelines are met.</p> <p>A follow-up questionnaire will be completed by the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 different staff members daily for 4 weeks beginning 6/5/14, to ensure continued understanding regarding the abuse/neglect policy, appropriate reporting, identification, and implementing care plans to meet resident care needs.</p> <p>A Quality Assurance meeting will be held weekly for 4 weeks beginning 5/28/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 68</p> <p>Performance improvement process was added in the orientation process for all newly hired staff members. No newly hired employee would be allowed to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and re-tested. This process continued until employees obtained a 100% score on the post-test.</p> <p>—Staff questionnaires regarding abuse, including the question, "What would you do if a resident told you that you were mean to them?" were administered by the Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff to five staff members on each shift and different staff members until immediacy was removed. After removal of immediacy, ten staff questionnaires were administered to staff daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating, and reporting of abuse/neglect. The questionnaire also included questions related to the QAPI process to include reporting of concerns to the Administrator and floor staff participation in development of the QAPI plan. Results of the staff questionnaire were reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of the plan. At that time, based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure</p>	F 490	The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.	

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

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F 490	<p>Continued From page 69</p> <p>investigation of suspected abuse/neglect was investigated/completed and reporting guidelines were met.</p> <p>-HR performed an audit of all personnel files for any abuse concerns on 05/29/14. Items that were reviewed: Coaching and Counseling forms, suspension forms, and termination forms. Results of the audit were given to the Chief Nursing Executive on 05/30/14, to review for any abuse/neglect concerns that needed reporting. There were no concerns identified.</p> <p>-A nurse from the facility's regional team or corporate office had been on-site since 05/29/14 and remained in the facility daily until the jeopardy was removed. The nurses from the regional team or home office assisted with investigations, observed staff treatment of residents, performed chart audits, and provided oversight and consultation. The Chief Nurse Executive, Clinical Compliance Nurse, or Director of Clinical Programs were in daily contact with the regional nurse consultant and reviewed allegations.</p> <p>-All facility grievances filed since 04/01/14 were reviewed by the Administrator, DON, or Regional Nurse Consultant on 05/30/14 to determine if any items documented were a reportable event. The Administrator was notified of one allegation of possible abuse. The Administrator reported the allegations to the Office of Inspector General on 05/30/14. The Administrator, Social Services Director, or the Director of Nursing reviewed the grievances and incident/accident reports daily, until immediacy was lifted, which was initiated on 05/29/14, to determine if there were reportable allegations that had not been identified. The Social Services Director or the Director of Nursing</p>	F 490			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 70</p> <p>reported to the Administrator any identified allegations of abuse, neglect, or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect, or misappropriation to the Office of Inspector General, Adult Protective Services, and the Ombudsman.</p> <p>—An emergency resident council meeting was held on 05/30/14; the Administrator and SDC attended the meeting to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. The Social Services Director attempted to contact the POAs of all residents with BIMS scores less than 8 to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution on 05/30/14.</p> <p>—The Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, and Wound Care Nurse (one per shift) were to be on-site each shift to perform walking rounds in which ten residents (five with BIMS scores greater than 8 and five with BIMS scores less than 8) were visited by the Department Head and those residents that could be interviewed were interviewed regarding the staff treatment. The Department Head visited and a nurse conducted a skin check on the residents that were not able to be interviewed. The Department Head also spoke to nursing staff and State Registered Nursing Assistants (SRNAs) regarding any noted changes in the residents' behaviors. The facility Department Head also interviewed five staff</p>	F 490			

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

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F 490	<p>Continued From page 71</p> <p>members each shift regarding the types of abuse, who the facility's Abuse Coordinator was, when to report suspected abuse, what to do if the resident reported you were mean to them, etc., which began on 05/29/14 and continued until the immediate jeopardy was lifted. Results of resident and staff questionnaires were reported to the Administrator, DON, Regional Nurse Consultant, or Vice President (VP) of Operations daily and if the Administrator was not in the facility, the Department Director conducted the questionnaires and telephoned the Administrator or VP of Operations with the results of the resident and staff questionnaires. This continued until the immediate jeopardy was lifted.</p> <p>--The DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff immediately notified the Administrator of any concerns regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect, or misappropriation and ensured the resident was safe. A binder (which contains a resident roster in which the interview date and shift is noted next to the resident name), which is passed on to each Department Head assigned to perform the resident and staff questionnaires each shift, to ensure that residents with BIMS scores greater than 8 were interviewed and residents with BIMS scores less than 8 were visited and skin checks completed, began on 05/29/14 and continued until the jeopardy was lifted. The MDS Coordinators had the responsibility for updating the binder weekly to identify residents with BIMS scores greater than 8 and residents with BIMS scores less than 8. If</p>	F 490		

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

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F 490	<p>Continued From page 72</p> <p>abuse, mistreatment, neglect, or misappropriation was alleged during the interviews or visits or reported by a staff member, the Department Head ensured the resident was safe, reported to a Charge Nurse, the Charge Nurse removed the alleged perpetrator to a non-patient care area, and notified the Administrator, Director of Nursing, and/or Social Services Director/Abuse Coordinator. The alleged perpetrator was suspended and an investigation began immediately.</p> <p>--The Administrator, Director of Nursing, Social Services Director, or a member of the facility's regional staff reviewed all resident and staff questionnaires daily for any grievances/concerns. Investigations of grievances/concerns were initiated upon receipt, starting on 05/30/14.</p> <p>--Nursing Administration (DON, ADONs, Unit Managers, SDC, MDS staff, facility formulary nurse), or the Medical Records or Social Services Director, reviewed documentation in the Nursing Notes in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on ten different residents each day. If any of the above concerns were identified, the member of Nursing Administration first ensured the resident was safe by performing an assessment and then notified a Charge Nurse. The abuse policy was followed in which the alleged perpetrator was removed from a resident care area (if on duty) and the Administrator, DON, or Social Services Director was notified.</p> <p>--All resident charts were reviewed from 04/01/14 by Nursing Administration (DON, ADONs, Unit Manager, Staff Development Coordinator, MDS</p>	F 490			

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 490	<p>Continued From page 73</p> <p>staff, Facility Formulary Nurse, Medical Records, Marketing/Admissions, or Social Services Director) or regional/corporate nurses by 05/30/14 for any documentation regarding abuse with no new incident being identified. Ten charts were reviewed by a member of Nursing Administration or the facility's regional or home office nurse daily to ensure that no other abuse allegations had been documented but not reported. This continued until the immediate jeopardy was removed.</p> <p>--The Administrator, Director of Nursing, and Social Services Director reviewed and discussed all abuse investigations daily to ensure that the residents were protected, the alleged perpetrator was removed from the resident care area, reports to the Office of Inspector General were filed timely, and a thorough investigation was completed. The Administrator maintained an abuse investigation log that included documentation of the following: ensured protection of residents, removed perpetrator from resident care area, reports to the Office of Inspector General filed timely, and thorough investigations completed. The Administrator and one of the following, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant, reviewed the abuse investigation to ensure protection of the resident; that the perpetrator was removed from the resident care area; that reports to the Office of Inspector General were filed timely; and that a thorough investigation had been completed. This will occur daily until removal of immediate jeopardy.</p> <p>--For new reports of alleged abuse, neglect, or misappropriation of property, after the immediate jeopardy was removed, one of the following was</p>	F 490			

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 74</p> <p>contacted prior to making the final five-day investigation report to OIG: Signature Care Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator, or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or Chief Nursing Executive) ensured the resident was protected, report was filed timely, the perpetrator was removed from the patient care area, and a thorough investigation was completed.</p> <p>—With any new report of alleged abuse, neglect, or misappropriation of property, one of the following was contacted within 24 hours to review the abuse investigation to ensure that a thorough investigation was completed and reporting timelines were met: Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or CNE.</p> <p>—All incident reports from January 2014 to 03/28/14 were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any concerns of suspected neglect by 05/30/14. None was identified.</p> <p>—During care plan conference for each resident, any abuse/neglect concerns were discussed and abuse/neglect education, to include reporting, was provided to the resident and/or POA with supporting documentation noted.</p> <p>—Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the CEO daily until removal of immediacy beginning 05/29/14, then</p>	F 490			

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

PRINTED: 07/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2014
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F 490	<p>Continued From page 75 weekly for four weeks, and then monthly.</p> <p>--The DON, ADONs, or SDC observed the care delivery for any suspected abuse/neglect concerns on five residents daily until the removal of immediacy and then weekly (Monday through Friday). The results of the care delivery audits were reported to the QA Committee weekly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA Committee would determine at what frequency the audits needed to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigations of suspected abuse/neglect were investigated/completed and reporting guidelines were met.</p> <p>--A Quality Assurance meeting was held weekly for four weeks beginning 05/29/14, then monthly for recommendations and further follow-up regarding the above stated plan. At that time, based upon evaluation, the QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting was to be completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the Chief Executive Officer (CEO) daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>**The surveyors validated the Immediate</p>	F 490			

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 76</p> <p>Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interviews with Administrative Staff revealed the allegation involving Resident #32 was investigated and reported to the appropriate State agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and Interviews with Administrative staff revealed the allegation involving Resident #33 was investigated and reported to the appropriate state agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation that involved Resident #35 was investigated and reported to the appropriate state agency. The investigation included interviews with Resident #35, staff, and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's assessments for signs and symptoms of abuse and resident interviews revealed the facility completed them on 05/29/14. Interview with the Regional Nurse Consultant on</p>	F 490		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 77</p> <p>06/04/14 at 9:15 AM revealed as of 06/03/14, only six POAs had not been contacted so the facility sent the abuse/neglect questionnaire by certified mail to the POAs. A review of the abuse/neglect assessments, abuse/neglect audits, and abuse/neglect interviews revealed the Administrative staff provided validation and oversight.</p> <p>Review of Administrative staff education and testing, provided on 05/29/14, related to abuse/neglect policy, investigations, reporting, and the Quality Assessment process was reviewed and validated by the Chief Nursing Executive (CNE).</p> <p>Review of staff education and post-testing related to the abuse policy and procedure which included reporting, protection, and investigation requirements revealed the education was provided on 05/29/14, as per the AOC. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM, revealed during the staff in-service examples were given of different situations of abuse/neglect and the staff had to explain the appropriate actions. Further interview with the Regional Nurse Consultant revealed the facility had not hired any new employees.</p> <p>A review of the staff questionnaire regarding abuse was being done as reported in the AOC. Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed no issues had been identified through the staff questionnaires.</p> <p>Review of the HR Audits of personnel files revealed the CNE validated review by signature on the back of the audit forms. Interview with the</p>	F 490			

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

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F 490	<p>Continued From page 78</p> <p>Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed there were no issues identified with the review of the employee files.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed a corporate staff member had been at the facility since the jeopardy was identified and had been reviewing all allegations to ensure a thorough investigation was conducted. Further interview revealed the corporate staff was also conducting chart audits, observed staff treatment of residents, and provided consultation.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed all facility grievances filed since 04/01/14 were reviewed for possible allegations of abuse/neglect. The interview revealed one grievance was related to cigarettes that were missing. The incident was investigated with no concerns identified. Continued interview revealed the facility's smoking policy had recently been updated to account for all residents' cigarettes.</p> <p>Interviews on 06/04/14 with the Regional Nurse Consultant and SDC revealed a Resident Council meeting was held on 05/30/14 to discuss abuse/neglect concerns and education was provided on reporting abuse/neglect concerns without fear of retribution. The interview further revealed residents that did not attend the meeting were also provided education related to reporting abuse.</p> <p>Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed as of 05/29/14 a daily census was completed and residents were chosen by the Administrator to be</p>	F 490			

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

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 288 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 490	<p>Continued From page 79</p> <p>interviewed and to observe staff as they provided care to the resident which was done by Administrative Staff. The interview further revealed staff providing care to residents with a BIMS score less than 8 were interviewed about changes in the resident. The Administrator or a member of the regional team validated the interviews and observations of care were completed.</p> <p>Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed a binder with all questionnaires related to abuse/neglect was passed to each Department Head assigned to distribute the questionnaires. The interview further revealed the staff had notified the Administrator with the results of the questionnaires. A review of the binder revealed no issues were identified. The binder contained a resident roster which included the dates and shifts the residents had been interviewed or assessed. The binder had been updated as BIMS scores changed. There were no issues identified during the interviews.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed the Administrator or regional team member had reviewed all questionnaires with no issues identified. A review of the questionnaires revealed a signature validated the questionnaires had been reviewed.</p> <p>Interview with Administrative Nursing Staff on 08/04/14 revealed resident charts had been reviewed each day for entries in the Nurse's Notes that could be related to abuse or neglect.</p> <p>Interview on 06/04/14 with Administrative Nursing</p>	F 490			

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

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F 490	<p>Continued From page 80</p> <p>Staff revealed all resident charts had been audited from 04/01/14 for any documentation regarding abuse and no new concerns were identified. The interviews revealed ten charts continued to be reviewed daily for any new documented evidence of abuse that was not reported.</p> <p>Interview on 06/04/14 with Administrative Staff and the Regional Nurse Consultant revealed all abuse investigations had been discussed and reviewed daily to ensure the facility's abuse policy was followed to ensure the resident was protected, the perpetrator was removed from the resident care area, the incident was reported timely, and an investigation was completed. Further interview revealed the Administrator maintained an abuse log to ensure all areas of the investigations were completed. Continued interviews revealed the Administrator and one corporate staff member reviewed investigations to ensure they were complete.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed after the Immediate Jeopardy was removed new reports of alleged abuse investigations will be reviewed by a Corporate Staff Member prior to the five-day report being sent to OIG. The Corporate Staff member will ensure the resident was protected, the incident was reported timely, the perpetrator was removed from patient care area, and a thorough investigation was completed.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed new reports of abuse or neglect will be reported to a Corporate Staff Member within 24 hours to ensure an investigation was completed and the</p>	F 490			

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

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F 490	<p>Continued From page 81 reporting timelines were met.</p> <p>Interviews on 06/04/14 with Administrative Nursing Staff and the Regional Nurse Consultant revealed all incident reports that had been completed since January 2014 were reviewed for concerns related to abuse/neglect and none were identified.</p> <p>Interview on 06/04/14 with the MDS Coordinator revealed questions about concerns related to abuse/neglect and education about reporting abuse/neglect were added to the care plan conferences. The interview further revealed resident family members that attended the care plan conferences were questioned about abuse/neglect concerns in the facility and educated on how to report an abuse/neglect concern.</p> <p>Interviews on 06/04/14 with the Administrator and the Regional Nurse Consultant revealed administrative oversight was completed weekly and will continue monthly after the Immediate Jeopardy was removed.</p> <p>Interviews on 06/04/14 with the DON, ADON, and SDC revealed observation of staff as they provided care was completed for any suspected abuse/neglect concerns on a daily basis for five residents and will continue weekly after the removal of the Immediate Jeopardy. Continued interviews revealed the reports were reported to the QA Committee to determine the need for additional education concerns or change of the plan.</p> <p>Interviews on 06/04/14 with Administrative Staff revealed a Quality Assurance meeting had been</p>	F 490			

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

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F 490	Continued From page 82 held weekly beginning 05/29/14 and will be held weekly for four weeks and then monthly. The interviews further revealed evaluations by the Committee would determine the frequency and length of ongoing audits. Further interviews revealed corporate oversight had been in place since 05/29/14, on a daily basis, until the Immediate Jeopardy was removed and will continue weekly for four weeks and then will continue monthly.	F 490			
F 520 SS-J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	F-520 1. The allegation of abuse reported by residents # 32 and 35 were reported to the Office of Inspector General by 5/29/14 by the Director of Nursing and reported to APS, Ombudsman, MD and POA by 5/30/14 by the Director of Nursing, ADON or charge nurse. Resident # 32 and 35 have been physically assessed by a nurse and psychosocially assessed by the social services director by 5/30/14. Resident # 32 and 35 were interviewed and statement obtained by the house supervisor, director of nursing or social services director by 5/30/14. Alleged perpetrator for resident # 32 was suspended pending outcome of thorough investigation and alleged perpetrator for resident #35 is no longer employed by the facility. Thorough investigation initiated on residents #32, and 35 by 5/30/14 by the DON, ADONs, Social services director or regional nurse consultant. All residents have been assessed for any signs and symptoms of abuse/neglect. Those residents with BIMs >8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 5/29/14. Those residents with BIMs < 8 were physically assessed by the ADONs for any signs and symptoms of abuse/neglect along with all resident POA's contacted by social services director or chaplain to question any abuse/neglect concerns by 5/1/14. 2. An audit of all personnel records, to include any counseling, coaching, suspension and/or termination forms, was completed by the Human Resources Director and results reviewed by the Chief Nursing Executive by 5/30/14, to ensure compliance with federal and state regulations related to reporting any suspected abuse/neglect allegations and the employment of staff.	6/30/14	

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

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F 520	<p>Continued From page 83</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview, record review, and review of the facility's performance improvement plan, "Performance Improvement with Abaqls," dated 2012, and the "Abuse, Neglect and Misappropriation" policy dated April 2013, it was determined the facility failed to maintain a Quality Assessment and Assurance Committee to develop and implement appropriate plans of action to correct identified quality deficiencies for one (1) of three (3) sampled residents (Resident #32). On 05/25/14, staff observed bruising to Resident #32's arm and the resident made an allegation that "fat Pat" (identified by the facility as SRNA #2) "grabbed" his/her arm. Interview and record review revealed Administrative staff and the Quality Assurance Committee failed to ensure the allegations of abuse were reported immediately to State Agencies, failed to ensure residents were protected from further potential abuse while an investigation was conducted, and failed to ensure investigations of allegations included resident and staff interviews and assessment of other residents for signs of abuse and neglect. The facility failed to recognize that their established abuse policy for reporting abuse was not effective and therefore failed to implement any corrective actions to correct these problems. (Refer to F225, F226, and F490.)</p> <p>The facility's failure to ensure their Quality Assessment and Assurance Committee developed and implemented appropriate plans of action related to abuse prevention caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate</p>	F 620	<p>A review of all grievances and accidents/incidents from January 2014 to May 2014 was completed by DON, ADONs' SDC, MDS, by 5/30/14 to ensure all have been thoroughly investigated along with any suspected abuse/neglect identified was reported in accordance with state/federal law to ensure reporting guidelines have been met. 1 allegation was identified, reported in accordance with state/federal guidelines and thorough investigation completed.</p> <p>All residents were assessed for any suspected and/or allegations of abuse/neglect. Residents with BIMs score of > 8 were interviewed by the Social services director or chaplain by 5/30/14 for any suspected neglect issues and Residents with BIMs score of < 8 were assessed by DON, ADONs, FFN, or SDC by 5/30/14 for any s/s of suspected neglect along with residents PDA's were contacted and questioned by social services director or chaplain by 5/30/14 for any suspected abuse/neglect concerns. Abuse/neglect audits, assessments, interviews and questionnaires were reviewed by the Administrator, Regional Nurse Consultant or the Chief Nurse Executive by 5/30/14 for any indications of a abuse/neglect concerns.</p> <p>Chart audits to include review of nurses notes, dietary notes, social services notes, quality of life notes and interdisciplinary notes were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or Regional Nurse Consultant by 5/30/14 for all residents to identify any suspected abuse/neglect allegations that have not been reported.</p> <p>3. The facility department managers, to include, administrator, DON, ADONs, SDC, MDS, wound</p>		

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

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OMB NO. 0938-0391

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F 520	<p>Continued From page 84</p> <p>Jeopardy was determined to exist on 05/24/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520) with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226). The facility was notified of the Immediate Jeopardy on 05/29/14.</p> <p>An acceptable Allegation of Compliance was received on 06/02/14 which alleged removal of the Immediate Jeopardy on 06/31/14. A partial extended survey was conducted on 06/03/14 through 06/04/14. The State Survey Agency determined the Immediate Jeopardy was removed on 05/31/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and "D" at 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. (Refer to F225, F226, and F490).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect and Misappropriation," dated April 2013 revealed facility staff would report and investigate all allegations of verbal, sexual, physical, and mental abuse, corporal punishment, neglect, and involuntary seclusion of the resident and resident exploitation as well as misappropriation of resident property. According to the policy, all allegations would be reported immediately to the Administrator and other officials as required and the alleged staff would be immediately removed from the care of all residents. In addition, the policy revealed the Administrator/designee would</p>	F 520	<p>care nurse, BOM, QOL, maintenance director, Housekeeping director, DM, Marketing/Admissions, SSD, RSM, FFN MR and Chaplain received education from the Regional Nurse Consultant on 5/29/14 regarding the abuse/neglect policy and procedure which included - appropriately identifying any suspected abuse/neglect allegations, appropriate reporting in accordance with state/federal guidelines, ensuring safety of the residents, and conducting a thorough investigation along with the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and question and include examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident to resident altercations to include verbal or physical, and taking belongings or exploitation. Post-test was administered and 100% score obtained, if manager did not score 100% on post-test, then manager will be immediately re-educated and post-test re-administered. This process will continue until manager obtains a 100% score on post-test.</p> <p>Once the facility Administrator, DON, ADDNs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN were re-educated on the abuse policy they were then assigned to re-educate the staff on the abuse policy and procedure which included, but not limited to, reporting, protection and investigation requirements, which started on 5/29/14. No employee will be allowed to work until abuse</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 85</p> <p>make reasonable efforts to investigate and address alleged reports, concerns, and grievances.</p> <p>Review of the facility's performance improvement plan titled, "Performance Improvement with Abaqis," dated 2012, revealed the facility would conduct an ongoing performance improvement program designed to systematically monitor, evaluate, and improve the quality of resident care. The plan further stated the facility's Performance Improvement (PI) process was to be incorporated into the ongoing weekly clinical processes and was to ensure immediate concerns identified were promptly investigated, which included allegations of abuse.</p> <p>Review of incident reports and interviews revealed staff observed bruising to Resident #32's arm on 05/25/14 and the resident reported "fat Pat" (identified by the facility as SRNA #2) "grabbed" his/her arm.</p> <p>Review of the Daily Standup Meeting documentation dated 05/26/14, revealed the observation of Resident #32's bruised arm and the allegation made by the resident were discussed in the meeting.</p> <p>Interview conducted with the Staff Development Coordinator (SDC) on 05/29/14 at 4:37 PM, revealed Quality Assurance (QA) Standup meetings were conducted Monday through Friday. The SDC further stated she had attended the meeting on 05/26/14, and stated Resident #32's bruises and the statement made by Resident #32 had been discussed. However, the SDC stated the incident and the resident's statement had not been "discussed as an</p>	F 520	<p>education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. Education regarding the abuse policy and procedure, to include identification/reporting and the Quality Assurance Performance Improvement process will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until abuse education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test.</p> <p>Staff questionnaire regarding abuse, to include the question, "What would you do if a resident told you that you were mean to them?", is being administered by Administrator, DON, ADDNs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN to 10 different staff members daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating and reporting of abuse/neglect, and the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plan. Results of the staff questionnaire will be reported to the QA committee weekly for 4 weeks, starting on 5/29/14, to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will</p>		

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F 520	<p>Continued From page 86</p> <p>allegation of abuse" and the QA Committee had not recommended any actions to address the resident's report.</p> <p>An interview conducted with Assistant Director of Nursing (ADON) #1 on 05/29/14 at 5:31 PM revealed the facility's "quality concerns" were discussed during the Daily Standup Meetings, which were conducted Monday through Friday. ADON #1 confirmed Resident #32's statement that the SRNA had "grabbed" his/her arm and the bruises to the resident's arm had been discussed in the meeting with members of the QA Committee on 05/28/14. The ADON further stated the incident had been reported to the DON and the Administrator, who were responsible for conducting abuse investigations. Therefore, he "felt like it had been addressed." ADON #1 further stated no other actions were recommended by members of the QA Committee when the incident was discussed on 05/26/14.</p> <p>An interview with the Director of Nursing (DON) on 05/29/14 at 6:05 PM revealed the facility's Daily Standup Meetings were conducted Monday through Friday and were part of the facility's Quality Assurance Program. The DON further stated the incident and actions which had been taken related to the bruises to Resident #32's arm, along with the resident's statement that the SRNA had grabbed his/her arm, were discussed with members of the QA Committee during the Daily Standup Meeting on 05/28/14. However, the DON stated the incident was not identified to be an allegation of abuse, and the QA Committee had not recommended any actions to be taken.</p> <p>An interview conducted with the Administrator on 05/29/14 at 6:17 PM confirmed that the facility</p>	F 520	<p>determine at what frequency the staff questionnaire will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected Abuse/neglect was thoroughly investigated and completed along reporting guidelines are met.</p> <p>Hand in Hand training, module one, was initiated on 5/13/14 by SDC and completed on 6/4/14. There is an education calendar in which all modules have been scheduled to include all 6 modules over the next 6 months. Make up sessions will be offered until all employees have attended. New employees in orientation will receive the Hand in Hand training on a set schedule to ensure all 6 modules are completed.</p> <p>The Administrator, DON, ADDNs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN, will be on site daily for 4 weeks to perform walking rounds in which 10 residents (five with BIMs >8 and five with BIMs <8) will be visited by the department head and interviewed regarding staff treatment for those residents that can be interviewed and for those residents who are not able to be interviewed the department heads will visit the resident, skin check will be completed by nurse as well as speak to nurse and C.N.A. regarding any noted changes in resident behaviors. The facility department heads also will interview 10 different staff members daily regarding the types of abuse, who is the abuse coordinator, when is suspected abuse reported, what would you do if a resident told you that you were mean to them etc. which began on 5/29/14. Results of resident and staff</p>		

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F 520	<p>Continued From page 87</p> <p>had Daily Standup Meetings that were utilized as part of the facility's QA process and that facility concerns were discussed as a committee. The Administrator stated he had not attended the QA/Daily Standup Meeting on 05/26/14, when the incident related to the bruises observed on Resident #32's arm and the resident's allegation related to SRNA #2 had been discussed with members of the QA Committee. The Administrator stated he would have expected the facility's QA Committee to have determined the resident's report was an allegation of abuse. He stated facility staff should have reported and investigated the report in accordance with the facility's policy.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 06/02/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>-The allegation of abuse reported by Resident #32 was reported to the Office of Inspector General (OIG) on 05/27/14 by the DON. Resident #32 has a BIMS score greater than 8 and a statement was obtained on 05/25/14. The alleged perpetrator was suspended on 05/25/14. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the Assistant Directors of Nursing (ADONs) assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 Power of</p>	F 520	<p>questionnaire's will be reported to the Administrator, DON, Regional Nurse Consultant or VP of Operations daily and if the Administrator is not in the facility the Department Director conducting the questionnaires will telephone the Administrator or VP of Operations the results of the resident and staff questionnaires.</p> <p>The Administrator, DON, ADONs, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, RSM, Medical Records, HR, Wound Care, or FFN will notify Administrator of any concerns immediately regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect or misappropriation, ensuring resident is safe. A binder, which is passed on to each Department Head assigned to perform the resident and staff questionnaires daily, which contains a resident roster in which the interview date and shift is noted next to resident name to ensure that residents with BIMS >8 will be interviewed and residents with BIMS <8 will be visited, with skin checks completed, beginning on 5/29/14. The MDS Coordinators have the responsibility for updating the binder weekly to identify residents with BIMS >8 and residents with BIMS <8. If abuse, mistreatment, neglect or misappropriation is alleged during the interviews and or visits or reported by a staff member the Department Head will ensure the resident is safe, report to a charge nurse in which the charge nurse will remove the alleged perpetrator to a non-patient care area and notify the Administrator, Director of Nursing, and/or Social Services Director/Abuse Coordinator. The alleged perpetrator will be suspended and a thorough investigation will begin immediately.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 88</p> <p>Attorneys (POAs) for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted.</p> <p>—The allegation of abuse related to Resident #33 that occurred on 05/24/14 was reported to OIG on 05/29/14 by the DON and reported to Adult Protective Services (APS), the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. A facility nurse assessed Resident #33 on 05/29/14 and the resident had a psychosocial assessment completed by the Social Services Director on 05/30/14. Resident #33 was interviewed and a statement was obtained by the facility's Social Services Director on 05/30/14. The alleged perpetrator was no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with a BIMS score less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted.</p>	F 520	<p>The Administrator, Director of Nursing, Social Services or a member of regional staff will review all resident and staff questionnaires daily for any grievances/concerns and/or suspected allegations of abuse/neglect. Any suspected allegations of abuse/neglect will be immediately reported in accordance with state/federal guidelines and thorough investigations of any suspected allegations of abuse/neglect along with any grievances/concerns will be initiated upon receipt, starting on 5/30/14.</p> <p>During care plan conference for each resident any potential allegation of abuse/neglect will be discussed and education will be provided on whom to report abuse/neglect concerns by the MDS coordinator.</p> <p>The Administrator, Social Services Director or the Director of Nursing will review, daily, the grievances and incident/accident reports, starting 5/29/14, to determine if there are reportable allegations that have not been identified. Social Services Director or the Director of Nursing will report to the Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect or misappropriation in accordance with state/federal guidelines to meet reporting requirements.</p> <p>An emergency resident council meeting was held on 5/30/14, Administrator and SDC attended, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. All residents with BIMS < 8 POA's were attempted to be contacted by Social Services Director to discuss any abuse/neglect concerns and to provide</p>		

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F 520	Continued From page 89 -The allegation of abuse reported by Resident #35 was reported to the Office of Inspector General on 05/29/14 by the DON and reported to APS, the Ombudsman, the resident's physician, and the POA on 05/30/14 by the DON. Resident #35 was physically assessed by a nurse and psychosocially assessed by the Social Services Director on 05/30/14. Resident #35 was interviewed and a statement was obtained by the Social Services Director on 05/30/14. The alleged perpetrator is no longer employed by the facility. The facility's investigation was initiated and ongoing with a five-day report to be submitted to OIG on 05/30/14. All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8 for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully have been contacted. -All residents were assessed for any signs and symptoms of abuse/neglect. Those residents with BIMS scores greater than 8 were interviewed by the Social Services Director or Chaplain for any abuse/neglect concerns on 05/29/14. On 05/29/14, the ADONs assessed the physical status of residents with BIMS scores less than 8	F 520	education on whom to report any abuse/neglect concerns without fear of retribution on 5/30/14. Nursing Administration (DON, ADON, Unit Manager, Staff Development Coordinator, MDS staff, facility formulary nurse, medical records, or social service director) will review documentation in the chart in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on 5 residents starting on 6/5/14. Any of the above concerns identified, the member of Nursing Administration will first ensure resident is safe by performing an assessment, notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area (if on duty) and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed. Administrator will keep an abuse investigation log that will include documentation of the following: ensure resident is protected, report is filed timely, perpetrator is removed from patient care area and thorough investigation is completed. The Administrator will review the log daily as well as one of the following: Signature Care Consultant, VP of Operations, or Special Projects Administrator along with Chief Operating Officer or Chief Nursing Executive will review log for compliance weekly, starting on 6/5/14 for 4 weeks, then monthly. In the event of any new reports of alleged abuse, neglect or misappropriation of property, one of the following will be contacted within 24 hours and then again prior to making the final five day investigation report to OIG: Signature Care	

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F 520	<p>Continued From page 90</p> <p>for any signs and symptoms of abuse/neglect. The facility attempted to contact the 41 POAs for the residents with a BIMS score less than 8 to ask if they had any concerns related to abuse/neglect and successfully contacted 26; the Social Services Director, the Chaplain, the DON, and/or the Administrator will continue to attempt to contact the remaining 15 POAs until all have successfully been contacted. The Administrator, the Regional Nurse Consultant, and the Chief Nurse Executive reviewed abuse/neglect audits, assessments, interviews, and questionnaires on 05/30/14 for any indications of abuse/neglect concerns.</p> <p>--The facility's Regional Nurse Consultant from the corporate office re-educated the facility Administrator, the DON, the ADONs, the Minimum Data Set (MDS) Coordinator, the Staff Development Coordinator (SDC), the Director of Dining Services, the Business Office Manager, the Social Services Director, the Activities Director, the Chaplain, Marketing/Admissions, Medical Records, Human Resources, and Wound Care staff on 05/29/14 on the facility's abuse policy and procedure. The education included but was not limited to thorough investigations, reporting immediately, and the Quality Assurance Performance Improvement (QAPI) process, including reporting of concerns to the Administrator and floor staff participation in development of QAPI plans. This training was performed face to face in order to facilitate discussion and questions and included examples of items that would be considered as reportable: reports of staff being mean, injuries of unknown origin, withholding belongings, resident-to-resident altercations to include verbal or physical, and taking belongings or exploitation.</p>	F 520	<p>Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator or Chief Nursing Executive. The reviewer (Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator or Chief Nursing Executive) will insure the resident is protected, report is filed timely, the perpetrator is removed from the patient care area and a thorough investigation is initiated and completed.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive or Chief Operating Officer weekly starting 6/5/14 for 4 weeks, then monthly.</p> <p>DON, ADONs, or SDC will observe the care delivery, for any suspected abuse/neglect concerns on 1 resident/unit daily (Monday through Friday) starting on 6/5/14 for 4 weeks. Any concerns noted the nursing administration will first ensure resident is safe by performing an assessment and notify a charge nurse. The abuse policy will be followed in which the alleged perpetrator will be removed from a resident care area and the Administrator, DON, or Social Service Director will be notified. Administrator and/or DON will immediately report in accordance to state/federal guidelines and thorough investigation will be initiated and completed.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, Signature Care Consultant, Chief Nursing Executive, or Chief Operating Officer, weekly for 4 weeks beginning 6/5/14, then monthly.</p>		

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 520	<p>Continued From page 91</p> <p>Department administrative managers were not allowed to return to work until abuse education was provided, post-tests administered, and a score of 100% obtained. If the manager did not score 100% on post-test, then the manager was immediately re-educated and re-tested. This process continued until all managers obtained a 100% score on the post-test. All post-tests were reviewed for compliance by the Chief Nursing Executive (CNE).</p> <p>—After the facility Administrator, DON, ADONs, Minimum Data Set (MDS) Coordinator, Staff Development Coordinator (SDC), Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions staff, Medical Records staff or Director, Human Relations (HR) staff, or Wound Care staff were re-educated on the abuse policy, the Administrative staff was assigned to re-educate the staff on the abuse policy and procedure which included but was not limited to reporting, protection, and investigation requirements, which started on 05/29/14. The facility did not allow any employee to work until abuse education was provided, post-test administered, and 100% score obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and the post-test re-administered. This process continued until all employees obtained a 100% score on the post-test. Education regarding the abuse policy and procedure, including identification/reporting and the Quality Assurance Performance Improvement process was added in the orientation process for all newly hired staff members. No newly hired employee would be allowed to work until abuse education was provided, post-test administered, and 100% score</p>	F 520	<p>The Administrator or Signature Care Consultant will audit compliance of the above stated audits/reviews daily (M-F). Results of the audits/reviews, which include, resident interviews, resident skin checks, staff questionnaires, grievance log review, A/I review, chart documentation audits and care delivery audits will be reported to the QA committee weekly x 4 weeks to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits/reviews, along with monitoring for compliance, will need to continue. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected neglect was investigated and completed along with reporting guidelines are met.</p> <p>A follow-up questionnaire will be completed by the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 different staff members daily for 4 weeks beginning 6/5/14, to ensure continued understanding regarding the abuse/neglect policy, appropriate reporting, identification, and implementing care plans to meet resident care needs.</p> <p>A Quality Assurance meeting will be held weekly for 4 weeks beginning 5/28/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue.</p>		

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

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F 520	Continued From page 92 obtained. If the employee did not score 100% on the post-test, the employee was immediately re-educated and re-tested. This process continued until employee obtained a 100% score on the post-test. --Staff questionnaires regarding abuse, including the question, "What would you do if a resident told you that you were mean to them?" were administered by the Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff to five staff members on each shift and different staff members until immediacy was removed. After removal of immediacy, ten staff questionnaires were administered to staff daily to ensure continued understanding of the abuse/neglect policy and procedure, appropriate investigating, and reporting of abuse/neglect. The questionnaire also included questions related to the QAPI process to include reporting of concerns to the Administrator and floor staff participation in development of the QAPI plan. Results of the staff questionnaire were reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of the plan. At that time, based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigation of suspected abuse/neglect was investigated/completed and reporting guidelines were met. --HR performed an audit of all personnel files for	F 520	The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.		

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

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F 520	<p>Continued From page 93</p> <p>any abuse concerns on 05/29/14. Items that were reviewed: Coaching and Counseling forms, suspension forms, and termination forms. Results of the audit were given to the Chief Nursing Executive on 06/30/14, to review for any abuse/neglect concerns that needed reporting. There were no concerns identified.</p> <p>--A nurse from the facility's regional team or corporate office had been on-site since 05/29/14 and remained in the facility daily until the jeopardy was removed. The nurses from the regional team or home office assisted with investigations, observed staff treatment of residents, performed chart audits, and provided oversight and consultation. The Chief Nurse Executive, Clinical Compliance Nurse, or Director of Clinical Programs were in daily contact with the regional nurse consultant and reviewed allegations.</p> <p>--All facility grievances filed since 04/01/14 were reviewed by the Administrator, DON, or Regional Nurse Consultant on 05/30/14 to determine if any items documented were a reportable event. The Administrator was notified of one allegation of possible abuse. The Administrator reported the allegations to the Office of Inspector General on 05/30/14. The Administrator, Social Services Director, or the Director of Nursing reviewed the grievances and incident/accident reports daily, until immediacy was lifted, which was initiated on 05/29/14, to determine if there were reportable allegations that had not been identified. The Social Services Director or the Director of Nursing reported to the Administrator any identified allegations of abuse, neglect, or misappropriation immediately after their review. The Administrator will report any allegations of abuse, neglect, or misappropriation to the Office of Inspector</p>	F 520			

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 94 General, Adult Protective Services, and the Ombudsman.</p> <p>—An emergency resident council meeting was held on 05/30/14; the Administrator and SDC attended the meeting to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. The Social Services Director attempted to contact the POAs of all residents with BIMS scores less than 8 to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution on 05/30/14.</p> <p>—The Administrator, DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, and Wound Care Nurse (one per shift) were to be on-site each shift to perform walking rounds in which ten residents (five with BIMS scores greater than 8 and five with BIMS scores less than 8) were visited by the Department Head and those residents that could be interviewed were interviewed regarding the staff treatment. The Department Head visited and a nurse conducted a skin check on the residents that were not able to be interviewed. The Department Head also spoke to nursing staff and State Registered Nursing Assistants (SRNAs) regarding any noted changes in the residents' behaviors. The facility Department Head also interviewed five staff members each shift regarding the types of abuse, who the facility's Abuse Coordinator was, when to report suspected abuse, what to do if the resident reported you were mean to them, etc., which began on 05/29/14 and continued until the</p>	F 520		

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 95</p> <p>immediate jeopardy was lifted. Results of resident and staff questionnaires were reported to the Administrator, DON, Regional Nurse Consultant, or Vice President (VP) of Operations daily and if the Administrator was not in the facility, the Department Director conducted the questionnaires and telephoned the Administrator or VP of Operations with the results of the resident and staff questionnaires. This continued until the immediate jeopardy was lifted.</p> <p>-The DON, ADONs, MDS Coordinator, SDC, Director of Dining Services, Business Office Manager, Social Services Director, Activities Director, Chaplain, Marketing/Admissions, Medical Records, HR, or Wound Care staff immediately notified the Administrator of any concerns regarding the above resident and staff questionnaires related to abuse, mistreatment, neglect, or misappropriation and ensured the resident was safe. A binder (which contains a resident roster in which the interview date and shift is noted next to the resident name), which is passed on to each Department Head assigned to perform the resident and staff questionnaires each shift, to ensure that residents with BIMS scores greater than 8 were interviewed and residents with BIMS scores less than 8 were visited and skin checks completed, began on 05/29/14 and continued until the jeopardy was lifted. The MDS Coordinators had the responsibility for updating the binder weekly to identify residents with BIMS scores greater than 8 and residents with BIMS scores less than 8. If abuse, mistreatment, neglect, or misappropriation was alleged during the interviews or visits or reported by a staff member, the Department Head ensured the resident was safe, reported to a Charge Nurse, the Charge Nurse removed the</p>	F 520			

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 96</p> <p>alleged perpetrator to a non-patient care area, and notified the Administrator, Director of Nursing, and/or Social Services Director/Abuse Coordinator. The alleged perpetrator was suspended and an investigation began immediately.</p> <p>--The Administrator, Director of Nursing, Social Services Director, or a member of the facility's regional staff reviewed all resident and staff questionnaires daily for any grievances/concerns. Investigations of grievances/concerns were initiated upon receipt, starting on 05/30/14.</p> <p>--Nursing Administration (DON, ADONs, Unit Managers, SDC, MDS staff, facility formulary nurse), or the Medical Records or Social Services Director, reviewed documentation in the Nursing Notes in order to assess for any signs of documented evidence regarding abuse, neglect, or misappropriation daily on ten different residents each day. If any of the above concerns were identified, the member of Nursing Administration first ensured the resident was safe by performing an assessment and then notified a Charge Nurse. The abuse policy was followed in which the alleged perpetrator was removed from a resident care area (if on duty) and the Administrator, DON, or Social Services Director was notified.</p> <p>--All resident charts were reviewed from 04/01/14 by Nursing Administration (DON, ADONs, Unit Manager, Staff Development Coordinator, MDS staff, Facility Formulary Nurse, Medical Records, Marketing/Admissions, or Social Services Director) or regional/corporate nurses by 05/30/14 for any documentation regarding abuse with no new incident being identified. Ten charts</p>	F 520			

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 97</p> <p>were reviewed by a member of Nursing Administration or the facility's regional or home office nurse daily to ensure that no other abuse allegations had been documented but not reported. This continued until the immediate jeopardy was removed.</p> <p>–The Administrator, Director of Nursing, and Social Services Director reviewed and discussed all abuse investigations daily to ensure that the residents were protected, the alleged perpetrator was removed from the resident care area, reports to the Office of Inspector General were filed timely, and a thorough investigation was completed. The Administrator maintained an abuse investigation log that included documentation of the following: ensured protection of residents, removed perpetrator from resident care area, reports to the Office of Inspector General filed timely, and thorough investigations completed. The Administrator and one of the following, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant, reviewed the abuse investigation to ensure protection of the resident; that the perpetrator was removed from the resident care area; that reports to the Office of Inspector General were filed timely; and that a thorough investigation had been completed. This will occur daily until removal of Immediate jeopardy.</p> <p>–For new reports of alleged abuse, neglect, or misappropriation of property, after the immediate jeopardy was removed, one of the following was contacted prior to making the final five-day investigation report to OIG: Signature Care Consultant, VP of Operations, Chief Operating Officer, Special Projects Administrator, or Chief Nursing Executive. The reviewer (Signature Care</p>	F 520			

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2014
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F 520	<p>Continued From page 98</p> <p>Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or Chief Nursing Executive) ensured the resident was protected, report was filed timely, the perpetrator was removed from the patient care area, and a thorough investigation was completed.</p> <p>--With any new report of alleged abuse, neglect, or misappropriation of property, one of the following was contacted within 24 hours to review the abuse investigation to ensure that a thorough investigation was completed and reporting timelines were met: Signature Care Consultant, VP of Operations, Chief Operating Office, Special Projects Administrator, or CNE.</p> <p>--All incident reports from January 2014 to 03/29/14 were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any concerns of suspected neglect by 05/30/14. None was identified.</p> <p>--During care plan conference for each resident, any abuse/neglect concerns were discussed and abuse/neglect education, to include reporting, was provided to the resident and/or POA with supporting documentation noted.</p> <p>--Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the CEO daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>--The DON, ADONs, or SDC observed the care delivery for any suspected abuse/neglect concerns on five residents daily until the removal</p>	F 520			

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

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F 520	<p>Continued From page 99</p> <p>of immediacy and then weekly (Monday through Friday). The results of the care delivery audits were reported to the QA Committee weekly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA Committee would determine at what frequency the audits needed to continue. Concerns identified were corrected immediately and reported to the Administrator to ensure investigations of suspected abuse/neglect were investigated/completed and reporting guidelines were met.</p> <p>--A Quality Assurance meeting was held weekly for four weeks beginning 05/29/14, then monthly for recommendations and further follow-up regarding the above stated plan. At that time, based upon evaluation, the QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator had the oversight to ensure an effective plan was in place to meet resident well-being as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting was to be completed by the Special Projects Administrator, the Regional Vice President of Operations, a member of regional staff, or the Chief Executive Officer (CEO) daily until removal of immediacy beginning 05/29/14, then weekly for four weeks, and then monthly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>Review of the facility's investigation and interviews with Administrative Staff revealed the allegation involving Resident #32 was</p>	F 520		

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

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F 520	<p>Continued From page 100</p> <p>investigated and reported to the appropriate State agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation involving Resident #33 was investigated and reported to the appropriate state agency. The investigation included interviews with staff and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's investigation and interviews with Administrative staff revealed the allegation that involved Resident #35 was investigated and reported to the appropriate state agency. The investigation included interviews with Resident #35, staff, and residents and physical assessments of residents that were not interviewable. The investigation also included interviews with POAs, questioning for any concerns related to abuse or neglect.</p> <p>Review of the facility's assessments for signs and symptoms of abuse and resident interviews revealed the facility completed them on 05/29/14. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed as of 06/03/14, only six POAs had not been contacted so the facility sent the abuse/neglect questionnaire by certified mail to the POAs. A review of the abuse/neglect assessments, abuse/neglect audits, and</p>	F 520			

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

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F 520	<p>Continued From page 101</p> <p>abuse/neglect interviews revealed the Administrative staff provided validation and oversight.</p> <p>Review of Administrative staff education and testing, provided on 05/29/14, related to abuse/neglect policy, investigations, reporting, and the Quality Assessment process was reviewed and validated by the Chief Nursing Executive (CNE).</p> <p>Review of staff education and post-testing related to the abuse policy and procedure which included reporting, protection, and investigation requirements revealed the education was provided on 05/29/14, as per the AOC. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM, revealed during the staff in-service examples were given of different situations of abuse/neglect and the staff had to explain the appropriate actions. Further interview with the Regional Nurse Consultant revealed the facility had not hired any new employees.</p> <p>A review of the staff questionnaire regarding abuse was being done as reported in the AOC. Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed no issues had been identified through the staff questionnaires.</p> <p>Review of the HR Audits of personnel files revealed the CNE validated review by signature on the back of the audit forms. Interview with the Regional Nurse Consultant on 06/04/14 at 9:15 AM revealed there were no issues identified with the review of the employee files.</p> <p>Interview on 06/04/14 at 9:15 AM with the</p>	F 520			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OMB NO. 0938-0391

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F 520	<p>Continued From page 102</p> <p>Regional Nurse Consultant revealed a corporate staff member had been at the facility since the jeopardy was identified and had been reviewing all allegations to ensure a thorough investigation was conducted. Further interview revealed the corporate staff was also conducting chart audits, observed staff treatment of residents, and provided consultation.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed all facility grievances filed since 04/01/14 were reviewed for possible allegations of abuse/neglect. The interview revealed one grievance was related to cigarettes that were missing. The incident was investigated with no concerns identified. Continued interview revealed the facility's smoking policy had recently been updated to account for all residents' cigarettes.</p> <p>Interviews on 06/04/14 with the Regional Nurse Consultant and SDC revealed a Resident Council meeting was held on 05/30/14 to discuss abuse/neglect concerns and education was provided on reporting abuse/neglect concerns without fear of retribution. The interview further revealed residents that did not attend the meeting were also provided education related to reporting abuse.</p> <p>Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed as of 05/29/14 a daily census was completed and residents were chosen by the Administrator to be interviewed and to observe staff as they provided care to the resident which was done by Administrative Staff. The interview further revealed staff providing care to residents with a BIMS score less than 8 were interviewed about</p>	F 520			

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F 520	<p>Continued From page 103</p> <p>changes in the resident. The Administrator or a member of the regional team validated the interviews and observations of care were completed.</p> <p>Interview on 06/04/14 with the Regional Nurse Consultant and the Administrator revealed a binder with all questionnaires related to abuse/neglect was passed to each Department Head assigned to distribute the questionnaires. The interview further revealed the staff had notified the Administrator with the results of the questionnaires. A review of the binder revealed no issues were identified. The binder contained a resident roster which included the dates and shifts the residents had been interviewed or assessed. The binder had been updated as BIMS scores changed. There were no issues identified during the interviews.</p> <p>Interview on 06/04/14 at 9:15 AM with the Regional Nurse Consultant revealed the Administrator or regional team member had reviewed all questionnaires with no issues identified. A review of the questionnaires revealed a signature validated the questionnaires had been reviewed.</p> <p>Interview with Administrative Nursing Staff on 06/04/14 revealed resident charts had been reviewed each day for entries in the Nurse's Notes that could be related to abuse or neglect.</p> <p>Interview on 06/04/14 with Administrative Nursing Staff revealed all resident charts had been audited from 04/01/14 for any documentation regarding abuse and no new concerns were identified. The interviews revealed ten charts continued to be reviewed daily for any new</p>	F 520			

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F 520	<p>Continued From page 104</p> <p>documented evidence of abuse that was not reported.</p> <p>Interview on 06/04/14 with Administrative Staff and the Regional Nurse Consultant revealed all abuse investigations had been discussed and reviewed daily to ensure the facility's abuse policy was followed to ensure the resident was protected, the perpetrator was removed from the resident care area, the incident was reported timely, and an investigation was completed. Further interview revealed the Administrator maintained an abuse log to ensure all areas of the investigations were completed. Continued interviews revealed the Administrator and one corporate staff member reviewed investigations to ensure they were complete.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed after the Immediate Jeopardy was removed new reports of alleged abuse investigations will be reviewed by a Corporate Staff Member prior to the five-day report being sent to OIG. The Corporate Staff member will ensure the resident was protected, the incident was reported timely, the perpetrator was removed from patient care area, and a thorough investigation was completed.</p> <p>Interview on 06/04/14 at 9:15 AM, with the Regional Nurse Consultant revealed new reports of abuse or neglect will be reported to a Corporate Staff Member within 24 hours to ensure an investigation was completed and the reporting timelines were met.</p> <p>Interviews on 06/04/14 with Administrative Nursing Staff and the Regional Nurse Consultant revealed all incident reports that had been</p>	F 520			

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F 520	<p>Continued From page 105</p> <p>completed since January 2014 were reviewed for concerns related to abuse/neglect and none were identified.</p> <p>Interview on 06/04/14 with the MDS Coordinator revealed questions about concerns related to abuse/neglect and education about reporting abuse/neglect were added to the care plan conferences. The Interview further revealed resident family members that attended the care plan conferences were questioned about abuse/neglect concerns in the facility and educated on how to report an abuse/neglect concern.</p> <p>Interviews on 06/04/14 with the Administrator and the Regional Nurse Consultant revealed administrative oversight was completed weekly and will continue monthly after the Immediate Jeopardy was removed.</p> <p>Interviews on 06/04/14 with the DON, ADON, and SDC revealed observation of staff as they provided care was completed for any suspected abuse/neglect concerns on a daily basis for five residents and will continue weekly after the removal of the Immediate Jeopardy. Continued interviews revealed the reports were reported to the QA Committee to determine the need for additional education concerns or change of the plan.</p> <p>Interviews on 06/04/14 with Administrative Staff revealed a Quality Assurance meeting had been held weekly beginning 05/29/14 and will be held weekly for four weeks and then monthly. The interviews further revealed evaluations by the Committee would determine the frequency and length of ongoing audits. Further interviews</p>	F 520			

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F 520	Continued From page 106 revealed corporate oversight had been in place since 05/29/14, on a daily basis, until the Immediate Jeopardy was removed and will continue weekly for four weeks and then will continue monthly.	F 520			