

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

PRINTED: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/22/2014
NAME OF PROVIDER OR SUPPLIER CARMEL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD. OWENSBORO, KY 42303	
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F 000	<p>INITIAL COMMENTS</p> <p>**Amended**</p> <p>An Abbreviated/Partial Extended Survey investigating complaint #KY21603 was conducted on 04/29/14 through 05/22/14 to determine the facility's compliance with Federal requirements. Complaint #KY21603 was substantiated with deficiencies cited.</p> <p>On 05/06/14, another complaint, KY21669 was initiated and investigated during this abbreviated survey and was found to be substantiated with deficiencies cited.</p> <p>On 04/08/14 at approximately 11:00 AM, Certified Nurse Aide (CNA) #1 reported that she recorded a video on 04/07/14 at approximately 3:00 AM, of Licensed Practical Nurse (LPN) #1 in the Nurse's Station with Resident #1. Facility staff had three (3) over the bed tables surrounding the resident's chair. The LPN displayed unprofessional verbally abusive behavior towards Resident #1 which included taunting, calling him/her "a brat", and pointing her finger at the resident until the resident was heard sobbing and crying on the video recording. CNAs #1, #2 and #3, who observed LPN #1 mistreat the resident, failed to report the incident to the Administrator immediately.</p> <p>On 05/01/14 at the end of the shift, CNA #5 reported that on 05/01/14 at approximately 7:30 PM she observed Certified Medication Technician (CMT) #1 holding Resident #4's hands and legs while LPN #3 pulled him/her backwards down the entire length of the hallway in a wheelchair. In addition, CNA #5 reported CMT #1 treated</p>	F 000		

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

TITLE

(X6) DATE

M. Francis Teresa Stulley *Adm* *July 3 2014*

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

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F 000	<p>Continued From page 1</p> <p>Resident #4 roughly when she undressed the resident and moved the wheelchair abruptly causing the resident to be suspended by a soft belt restraint off the edge of his/her wheelchair. The CMT then roughly grabbed Resident #4 and "flung" him/her onto the bedside. LPN #3 and CNA #5, who observed the CMT treat the resident in this manner, failed to report the incident to the Administrator immediately.</p> <p>Immediate Jeopardy was identified in the areas of 483.13 Resident Behavior and Facility Practice; F-223, F-225, F-226 and Resident Assessment; F-282 at a Scope and Severity of a "J".</p> <p>Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practice. Immediate Jeopardy was identified on 05/01/14 and was determined to exist on 04/07/14. The facility was notified of Immediate Jeopardy on 05/01/14.</p> <p>An acceptable Allegation of Compliance (AoC) was received on 05/09/14, alleging the removal of Immediate Jeopardy on 05/06/14. The State Survey Agency validated, on 05/22/14, that the Immediate Jeopardy was removed on 05/06/14, as alleged. The Scope and Severity was lowered to a "D" at 482.13 Resident Behavior and Facility Practices, F-223, F-225 and F-226; and, 483.20 Resident Assessment, F-282; while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) Committee monitors the effectiveness of the systemic changes.</p>	F 000		
F 223 SS=J	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal,</p>	F 223		

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F 223	<p>Continued From page 2</p> <p>sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of a video recording, record review and review of the facility's policy and procedure, it was determined the facility failed to have an effective system in place to ensure two (2) of nine (9) sampled residents (Residents #1 and #4) were free from abuse.</p> <p>Licensed Practical Nurse (LPN) #1 was video recorded via cellular phone, by Certified Nurse Aide (CNA) #1, on 04/07/14. The video recording revealed LPN #1 and Resident #1 were sitting at the Nurse's Station. Staff had placed three (3) over the bed tables around the resident to prevent him/her from wandering. LPN #1 was observed calling the resident an inappropriate name, pointing and shaking her finger at the resident, and talking to the resident in a commanding tone for approximately four (4) minutes. Resident #1 was audibly crying. Further review revealed there were three (3) staff members, CNA #1, CNA #2 and CNA #3, who observed this behavior, but failed to intervene or protect this resident and other residents by reporting the incident immediately to the Administration.</p> <p>Additionally, on 05/01/14 at 7:30 PM, CNA #5 observed Certified Medication Technician (CMT#1) grab Resident #4's hands lightly and</p>	F 223	<p>Criteria 1: -Upon notification of the allegation of abuse regarding resident #1, the Administrator (ADM) suspended the Licensed Practical Nurse (LPN) identified in the allegation, on 4/8/14. The LPN was terminated on 4/11/14, and the event reported to the Kentucky Board of Nursing (KBN).</p> <p>-Resident #1 was assessed by the Assistant Director of Nursing (ADON) on 4/8/14 for any signs/symptoms of injury or distress, with none identified.</p> <p>-The Medical Doctor (MD) and responsible party for Resident #1 were notified of the allegation of abuse, the reporting of the allegation to the required authorities, and that an investigation was underway on 4/8/14.</p> <p>-Upon notification of the allegation of abuse regarding resident # 4, the Director of Nursing (DON) suspended the Certified Medical Technician (CMT)—on 5/2/14 and LPN—on 5/1/14—identified in the allegation, pending</p>	

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F 223	<p>Continued From page 3</p> <p>hold the resident's hands in his/her lap. CMT #1 and LPN #3 then wheeled the resident backwards down the entire length of the hallway to the resident's room in a wheelchair. Once in the room, CMT #1 roughly removed Resident #4's sweater, jerked the wheelchair backward causing the resident to become suspended, by the soft belt restraint, above the fall mat in his/her room. CMT#1 then lifted Resident #4 from the wheelchair and "flung" him/her on the side of the bed. CNA #5 and LPN #1 failed to intervene or report this incident immediately to Administration.</p> <p>The facility's failure to ensure residents were free from abuse has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 05/01/14 and was determined to exist on 04/07/14. The facility was notified of the Immediate Jeopardy on 05/01/14.</p> <p>The findings include:</p> <p>Review of the facility's "Resident Safe Environment" policy and procedures, (not dated), revealed each resident has the right to be free from verbal, physical, sexual, and mental harassment or abuse. The policy included the following definitions: Abuse- the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish; Verbal Abuse - any use of oral, gestured, language that includes disparaging and derogatory terms to residents regardless of their ability to comprehend; Physical Abuse - as controlling behavior through corporal punishment; and Mental Abuse: as harassment, threats of punishment or deprivation. Any alleged incidents of abuse, neglect, or exploitation must be</p>	F 223	<p>investigation. Both were terminated, on 5/8/14, as a result of the investigation findings.</p> <p>-Resident #4 was assessed by the DON on 5/1/14 for any signs/symptoms of injury or distress, with none identified.</p> <p>-The MD and responsible party for resident #4 were notified of the allegation of abuse, the reporting of the allegation to the required authorities, and that an investigation was underway on 5/2/14.</p> <p>Criteria 2: -The ADON conducted physical assessments on all of the non-interviewable Infirmatory (SNF/NF) residents on 4/8/14 and 5/2/14 for signs/symptoms of injury/possible abuse, and conducted interviews on 4/8/14 and 5/2/14 of all interviewable residents (BIMS score of 9 or higher), with no injuries or allegations noted or reported.</p> <p>-The Care Plans and C.N.A Care Plans</p>		

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F 223	<p>Continued From page 4</p> <p>reported immediately to the appropriate supervisor; the Administrator of the facility must be immediately notified.</p> <p>1. Record review revealed the facility admitted Resident #1 on 05/09/13, with diagnoses which included Alzheimer's Disease, Hypertension, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/14/13, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable.</p> <p>On 04/29/14, at 9:37 AM, review of the cellular phone video recording, dated 04/07/14 at approximately 3:00 AM, revealed Resident #1 was sitting at the Nurse's Station with three (3) over the bed tables placed around the resident to prevent him/her from wandering. LPN #1 was observed on the video calling Resident #1 "a brat", and telling the resident to "sit down" in a commanding voice repeatedly for approximately four (4) minutes. Resident #1 was audibly crying. Further review revealed two (2) other staff members, CNA #1 and CNA #2, who were partially visible and, the voice of a third staff member (identified by the Director of Nursing as CNA #3). The three (3) CNAs observed LPN #1 blocking Resident #1 in the Nurse's Station and heard the verbal remarks made to Resident #1 by LPN #1.</p> <p>Interviews with CNA #1, CNA #2 and CNA #3, on 04/29/14 at 2:45 PM and 3:10 PM; and, on 04/30/14 at 9:05 AM respectively, revealed they observed LPN #1 blocking the resident in the Nurse's Station so he/she could not wander on 04/07/14. CNA #1 and CNA #3 stated the LPN</p>	F 223	<p>for all Infirmiry residents were reviewed/ revised by the MDS Coordinator and QA Nurse to determine that they reflected resident behaviors and the appropriate interventions for staff to manager the behaviors, as completed by 5/2/14.</p> <p>Criteria 3: -Inservice education was provided for all staff on the abuse policy components, the types of abuse, the need to protect the resident and report abuse immediately, and how to recognize signs/symptoms of staff burnout on 4/11, 4/14, and 5/5 by the ADON. A post-test was provided at the conclusion of the inservice training on 5/5/14 to verify staff comprehension of the training information. Any staff not meeting the threshold of 100% were re-educated until this threshold was met.</p> <p>-All staff who were not present at the inservice training on 5/5/14 were prevented from working</p>	

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F 223	<p>Continued From page 5</p> <p>called the resident "a brat" and kept telling the resident repeatedly to "sit down". The CNAs stated they were intimidated by the LPN and she treated them like she was a "Drill Sergeant". Further interview with the CNAs revealed LPN #1 had previously told them to sit with Resident #1 and block him/her from walking freely on numerous occasions. The CNAs stated they did not report any of the incidents because of fear of retaliation by the LPN. CNA #1 stated she waited and reported the incident on 04/08/14 when the LPN was not at work.</p> <p>Interview with the Director of Nursing, on 04/29/14 at 9:37 AM, revealed she was not made aware of the video recording and the alleged abuse until 04/08/14 around 11:00 AM. She stated CNA #1 reported the incident and made the video recording. Further interview revealed the video recording lasted several minutes but the incident actually occurred over several hours. The DON stated the CNAs should have called the Administrator or the Assistant Director of Nursing immediately as they live in the facility.</p> <p>2. Record review revealed the facility admitted Resident #4 on 01/20/14 with diagnoses which included Advanced Age with Dementia, Combative, and Depression. Review of the Quarterly MDS Assessment, dated 04/18/14, revealed the facility assessed Resident #4's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6), which indicated the resident was not interviewable.</p> <p>Interview with CNA #5, on 05/06/14 at 3:47 PM, revealed she witnessed CMT #1 and LPN #3 mistreat Resident #4 on 05/01/14 at</p>	F 223	<p>until completion of the training and the post test, by the removal of their time cards.</p> <p>Criteria 4: -The abuse allegation events, the investigation, and the action plan were reviewed with the Medical Director in a QA meeting conducted on 5/5/14.</p> <p>-The CQI indicator for the monitoring of compliance with the abuse regulations will be utilized with any allegation that occurs for the next 2 months, then monthly X 6 months beginning within one month from 5/6/14, and then quarterly thereafter under the supervision of the DON. This tool reviews compliance with the interventions required by the regulation for an allegation of abuse, including but not limited to: reporting, protecting the resident, investigating, and notifying.</p> <p>-Results of the audits are reported to the QA Committee by the DON quarterly, with the most</p>		

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F 223	<p>Continued From page 6</p> <p>approximately 7:30 PM. CNA #5 stated she saw CMT #1 grasp Resident #4's hands tightly and cross the resident's hands across his/her lap as LPN #3 pulled the resident's wheelchair backwards down the length of the hall taking Resident#1 into his/her room. CNA #5 revealed she observed CMT #1 roughly remove Resident #4's sweater and pull the wheelchair from under Resident #4 causing the resident to be suspended above the fall mat in his/her room. CMT#1 then roughly lifted Resident #4 from the wheelchair and "flung" him/her on the side of the bed. CNA #5 stated LPN #3 and she witnessed the incident; however, neither of them reported CMT #1's behavior to administration until the end of the shift at 10:30 PM when CNA #5 reported the incident to the DON. The CNA stated she waited for LPN #3 to report the incident; but when the LPN had not reported the incident by the end of the shift, she called the DON.</p> <p>Interview with LPN #3, on 05/07/14 at 1:50 PM, revealed on 05/01/14 at approximately 7:30 PM, Resident #4 was in the wrong room going through another resident's drawers. The LPN stated she attempted to redirect the resident but the resident began screaming. LPN #3 stated CMT #1 then came into the hallway and "pried the resident's hands off the wheels of the wheelchair and grasped them tightly and crossed them across the resident's lap." Further interview revealed she pulled Resident #4 backwards down the hallway and into the resident's room. LPN #3 recalled CMT #1 pulling Resident #4's sweater off over his/her head roughly and lifted the resident and put him/her on the bedside. LPN #3 stated, "It was shift change before I realized it and I did not report the incident." When LPN #3 was asked why she did not report the incident she stated, "I</p>	F 223	<p>recent meeting taking place on 6/3/14. If an accepted threshold of compliance, as referenced on the CQI tool, is not achieved, the DON shall develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next scheduled meeting.</p> <p>-Staff were questioned as chosen randomly on the abuse policy components weekly X 2 weeks as completed by the ADON beginning on 5/5/14.</p> <p>-The completed CQI indicators for the monitoring of compliance with the abuse regulations, and any action plans developed related to these indicators, will be reviewed by the Nurse Consultant with monthly visits.</p> <p>Criteria 5:</p>		

June 4
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F 223	<p>Continued From page 7</p> <p>just didn't". The LPN stated she did not think her pulling the resident backwards down the hallway and allowing CMT #1 to roughly handle the resident as abusive behavior.</p> <p>Telephone interview with CMT #1, on 05/07/14 at 2:45 PM, revealed she was driving and could not talk at the time; however, she had typed a statement for the DON and stated the Surveyor could review the typed statement. Review of the typed statement signed by CMT #1, revealed Resident #4 was upset and was wheeling towards the wrong room and became very angry and was yelling at her. The CMT documented she called for LPN #3 to come to assist her and wheeled the resident to his/her room at which time the resident was kicking and screaming at her. The documentation revealed she pulled Resident #4's sweater off over his/her head; however, she did not feel she was rough. She then pulled the wheelchair at which time Resident #4 slid out of the chair putting pressure on his/her ribs with the soft seat belt. She documented she then picked Resident #4 up and sat him/her on the bedside. Further review revealed she had documented that she felt frustrated with Resident #4's behavior and left the room at that time. Interview with CMT #1, on 05/07/14 at 3:08 PM, revealed she confirmed the written statement read aloud to her. She further stated she did not feel she was rough with the resident.</p> <p>Interview with the Administrator and DON, on 05/06/14 at 2:45 PM, revealed they were both in the building when this incident occurred and the CNA should have reported it immediately. Further interview with the DON, on 05/07/14 at 3:15 PM, revealed she expected staff to redirect Resident #4 when he/she went into another</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>resident's room and the staff should wheel the wheelchairs in a forward motion unless "they have to pull a wheelchair backwards through a doorway threshold.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 04/08/14, the facility suspended, then terminated LPN #1. The incident involving LPN #1 was then reported to the Kentucky Board of Nursing by the facility's DON.</p> <p>On 04/08/14 and 05/05/14, the Assistant Director of Nursing (ADON) conducted physical assessments on all the non-interviewable residents for signs/symptoms of possible abuse and interviews on all interviewable residents; no injuries were found. Further on 05/02/14, the ADON conducted interviews on all interviewable residents (those with a Brief Interview for Mental Status (BIMS) score of nine (9) or higher to identify concerns related to care or any staff member, or events involving possible mistreatment by the staff or others with no concerns identified. The Nurse Care Plans for all residents were reviewed and updated with focus on interventions specific to the resident's behaviors.</p> <p>The facility began interviewing employees on 04/08/14 and repeated the interviews on 05/05/14 as education and re-education and training as part of their in-service training on the facility's abuse policy. Time cards were removed from the clock-in area and were not issued to the employees until the re-education was completed.</p> <p>Quality Assurance (QA) monitors began on</p>	F 223			

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F 223	<p>Continued From page 9</p> <p>05/05/14 and included all facility staff and Continuous Quality Improvement (CQI) indicators for monitoring compliance with Care Planning to be conducted monthly for six (6) months beginning one month from 05/06/14 then quarterly thereafter under the supervision of the DON. Audits to be reported to the QA committee and a threshold of compliance is referenced as no abusive situations or reports. Compliance rounds are to be conducted weekly by the Administrator nursing staff to ensure compliance with resident care interventions being provided in accordance with the care plan.</p> <p>The State Agency validated the Corrective Action taken by the facility as follows:</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she was aware the Director of Nursing (DON) reported LPN #1's abusive behavior to the Kentucky Board of Nursing (KBN) on 05/02/14.</p> <p>Further interview on 05/22/14 at 4:00 PM with the Administrator revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14; LPN #3 is not eligible for rehire. CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility according to the Administrator.</p> <p>Additionally, interview on 05/22/14 at 4:00 PM with the Administrator revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administrator in a</p>	F 223			

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F 223	<p>Continued From page 10</p> <p>timely manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Interview on 05/22/14 at 4:30 PM with the Assistant Director of Nursing (ADON) revealed she was aware the DON reported LPN #1's abusive behavior to the KBN on 05/02/14.</p> <p>Further interview on 05/22/14 at 4:30 PM with the ADON revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14 and is not eligible for rehire; further CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility.</p> <p>Additionally, interview on 05/22/14 at 4:30 PM with the ADON revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administration in a timely manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Record review on 05/22/14 at 5:10 PM revealed an Employee Exit Interview dated 04/16/14 that shows LPN #1 was terminated on 04/16/14 and is not eligible for rehire. Further record review revealed LPN #3 and CMT #1 were suspended on 05/01/14 and 05/02/14 respectively, and then employment from the facility was terminated on 05/12/14 and neither are eligible for rehire at the facility. Additionally; CNA #1, CNA #2, CNA #3 received final written warnings and any future infraction will result in termination of employment</p>	F 223		

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F 223	<p>Continued From page 11</p> <p>at the facility, CNA #5 received counseling related to the reporting of abuse, neglect or mistreatment of residents to administration immediately.</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she had oversight and that the ADON had conducted physical assessments and individually interviewed all residents of the Skilled Nursing Facility (SNF) on 04/08/14 and no findings of abuse were identified. Additionally she stated the ADON conducted mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p> <p>Interview on 05/22/14 at 4:30 PM with the ADON revealed she conducted physical assessments and individually interviewed all residents of the SNF on 04/08/14 and no findings of abuse were identified. Additionally she states she conducted mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p> <p>Record review on 05/12/14 at 3:00 PM revealed the physical assessments and the interviews with all residents of the SNF were conducted and recorded by the ADON and that no concerns were identified.</p> <p>Interview on 05/07/14 at 8:15 AM with the MDS Coordinator, who is a Registered Nurse (RN) revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or Administrator immediately, if the incident involved</p>	F 223			

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F 223	<p>Continued From page 12</p> <p>a superior she would go "up the chain of command" and notify the DON or one of the "Sisters".</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters, further stating the abuse hotline number was posted beside the time clock.</p> <p>Interview on 05/07/14 at 8:40 AM with a Housekeeper revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14. Her signature was noted on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go higher up or notify the DON or one of the Sisters.</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p>	F 223		

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F 223	Continued From page 13 Interview on 05/22/14 at 5:29 PM with RN #2 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or Administrator immediately, if the incident involved a superior she would go to a higher up and notify the DON or one of the Sisters. She stated the primary concern was to keep the resident safe and remove the alleged perpetrator from the building immediately, "it's not just that we hear about abuse and have inservices on them, if you have a gut feeling something is wrong you do something about it." Interview on 05/07/14 at 5:45 PM with CNA #12 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command", or notify the DON or one of the Sisters. She further stated, "We have in-services and meetings frequently it seems, several times since I came seven (7) months ago, it's like fire and severe weather drills you should know what to do, wrong is wrong, report it immediately. Go to a nurse, if it's a nurse call the ADON or the DON and there's the numbers by the time clock for the Hotline if you need it." Interview on 05/22/14 at 5:50 PM with CMT #2 revealed she received in-service training on	F 223			

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F 223	<p>Continued From page 14</p> <p>abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON, or one of the Sisters.</p> <p>Interview on 05/22/14 at 6:00 PM with CNA #11 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety, abuse or mistreatment of any kind to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would call the DON or one of the Sisters. She further stated they gave us all a sheet with their numbers on it so we can call them anytime we need to, as well. The Sisters have beepers if we need them.</p> <p>Interview on 05/07/14 at 6:05 PM with CNA #13 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/07/14 at 6:15 PM with a Dietary Staff Member revealed she received in-service</p>	F 223			

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F 223	<p>Continued From page 15</p> <p>training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/06/14 at 3:45 PM with the DON revealed she assigned the MDS Coordinator to review all residents' care plans on 04/11/14 and 05/05/14 for appropriateness, applicable problems, goals and interventions or approaches. The Nurse's Care Plans were reviewed and updated every quarter according to the resident's date their Minimum Data Set (MDS) was completed.</p> <p>Interview on 05/06/14 at 2:40 PM with the MDS Coordinator/RN revealed she conducted the review and update of the care plans. She stated usually this was an ongoing process, "I am out here with the residents and staff talking to the residents and we all talk about what is appropriate for whom and I update the care plans every third month, they reflect the MDS, and the CNA's care plan reflects the Nurse's Care Plan. We all give input and if we see any inconsistencies with the resident's ability we notify Sister, the ADON.</p> <p>Interview on 05/12/14 at 2:40 PM with LPN #2 revealed she was familiar with the review and update of the care plans. She stated the MDS Coordinator usually updates them every month. LPN #2 stated the MDS Coordinator was out on the Unit talking to the residents and staff.</p>	F 223			

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F 223	<p>Continued From page 16</p> <p>Interview on 05/12/14 at 4:55 PM with RN #1 revealed she recalled all staff was verbally reminded of the importance of following each resident's care plan. An example was voiced of walking with the resident if that is what the care plan indicated, if we don't see that it is followed we are not doing the right nursing care. As an RN, "I must see that the care plans are followed for the resident's well being."</p> <p>Interview on 05/22/14 at 5:29 PM with RN #2 revealed she has worked in the facility for one (1) month and was familiar with the review and update of the care plans. She stated the MDS Coordinator usually does that every so often. She further stated the MDS Coordinator was out on the Unit talking to the residents and staff. We all give input and if we see any inconsistencies we notify "Sister, the ADON".</p> <p>Review on 04/30/14 at 4:00 PM revealed in-service logs entitled "Resident safe Environment" and staff roster with signatures indicating attendance, dated 04/11/14. This inservice covered wheelchair safety, stress, burn-out, coping, gait belt use, oral care, cell phone use; and, abuse inservice signatures which indicated ninety- four (94) staff members attended the in-service between 04/11/14 and 04/14/14.</p> <p>Review on 05/12/14 of the in-service logs, dated 05/05/14, revealed all staff was inserviced related to abuse, neglect, recognizing and reporting signs of stress and burn-out, and following the plan of care.</p> <p>On 05/12/14 at 2:10 PM, CNA #9 verified through</p>	F 223			

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F 223	<p>Continued From page 17</p> <p>interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p> <p>Interview on 05/12/14 at 2:17 PM with CNA #10; and at 2:40 PM with LPN #4, revealed they had received the in-service education on 05/02/14 by the ADON and they were aware of the signs/symptoms of abuse. The training also included to report to a supervisor immediately any allegation or witnessed abusive situations and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer.</p> <p>On 05/12/14 at 2:45 PM, a housekeeper verified through interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p> <p>On 05/12/14 at 4:55 PM, RN #1; on 05/22/14 at 5:29 PM with RN #2, and at 5:50 PM with CMT #2 verified through interview that they had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings. The inservice also included caregiver stress and signs of burn-out, and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer.</p> <p>Interview on 05/22/14 at 5:55 PM with CNA #11 revealed she had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to</p>	F 223		

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F 223	<p>Continued From page 18</p> <p>call on one of the Nuns even to the point of interrupting prayer. She stated, "I would get a Sister because I feel like we should treat these people like they are our grandparents and you want your grandparents treated well."</p> <p>On 05/22/14 at 5:45 PM, CNA #12 verified through interview that she had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to call on one of the nuns even to the point of interrupting prayer."If it's wrong it's wrong, you can't let somebody get away with treating somebody mean you got to tell someone."</p> <p>Record review on 05/22/14 at 6:00 PM revealed the abuse allegations, the investigations, and the action plan was reviewed. Further review of a form entitled Continuous Quality Improvement; the Indicator: Knowledge and Compliance of Abuse and Reporting Policy; Recognizing Stress and Burn-out revealed one-hundred-seven (107) [all the facility staff] staff members received the re-education and in-service training and signed the rosters, their time-cards were held until their signatures were obtained in statement of participation. Through explanation by the ADON, random employees were asked Criteria/Question such as: stating the chain of command, know when to report, Identifies signs/symptoms of self stress and self burnout, names of coping strategies, know where to find contact numbers for reporting abuse. Each department will conduct these compliance rounds weekly and calculate the percentage of compliance. This will be</p>	F 223		

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F 223	Continued From page 19 conducted under the supervision of the DON and results will be reported to the QA committee. If an acceptable threshold of compliance is not achieved the DON will develop and oversee a corrective action. Compliance rounds are conducted weekly by the Administrative nursing staff to determine that resident care interventions are being provided in accordance with the care plan. Interview on 05/22/14 at 6:15 PM with the Medical Director revealed he was informed of the timing for the QA Committee meetings and he had attended the primary discussion with the Administrator, DON and ADON on 05/06/14. Further interview revealed he felt the facility was taking responsibility and being proactive with the QA plan they have put in place.	F 223			
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225			

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F 225	<p>Continued From page 20</p> <p>immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of the phone video recording, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure staff reported observed incidents of abuse for two (2) of nine (9) sampled residents (Resident #1 and Resident #4), immediately to the Administration of the facility.</p> <p>Review of a cellular phone video recording revealed on 04/07/14 at approximately 3:00 AM, Licensed Practical Nurse (LPN) #1 had Resident #1 sitting in the Nurse's Station with over the bed tables placed around the resident to prevent him/her from wandering. LPN #1 was calling Resident #1 "a Brat", and pointing and shaking her finger at the resident and telling the resident</p>	F 225	<p>Criteria 1: -Upon notification of the allegation of abuse regarding resident #1, the ADM suspended the LPN identified in the allegation, on 4/8/14. The LPN was terminated, On 4/11/14, and the event reported to the KBN.</p> <p>-Resident #1 was assessed by the ADON on 4/8/14 for any signs/symptoms of injury or distress, with none identified.</p> <p>-The MD and responsible party for Resident #1 were notified of the allegation of abuse, the reporting of the allegation to the required authorities, and that an investigation was underway on 4/8/14.</p> <p>-Upon notification of the allegation of abuse regarding resident # 4, the DON suspended the CMT, on</p>	

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F 225	<p>Continued From page 21</p> <p>to "sit down" in a commanding tone for approximately four (4) minutes. Resident #1 was audibly crying. Further review revealed there were two (2) other staff members (Certified Nurse Aides (CNA) #1 and CNA #2) who were partially visible and the voice of a third staff member (identified by the Director of Nursing (DON) as CNA #3). The three (3) CNAs observed LPN #1 blocking Resident #1 in the Nurse's Station and heard the verbal remarks made to the resident by LPN #1. However, the CNAs failed to report the mistreatment of Resident #1 immediately to Administration, as per facility policy.</p> <p>Additionally, on 05/01/14 at 7:30 PM, CNA #5 observed Certified Medication Technician (CMT#1) grab Resident #4's hands tightly and hold the resident's hands in his/her lap. CMT #1 and LPN #3 then wheeled the resident backwards down the hallway to the his/her room. Once in the room, CMT #1 removed Resident #4's sweater roughly and then pulled the wheelchair from under Resident #4 causing him/her to be suspended above the fall mat in his/her room. CMT#1 then roughly lifted Resident #4 from the wheelchair and "flung" him/her on the side of the bed. LPN #3 and CNA #5 both observed CMT #1's treatment of Resident #4; however, they failed to report the mistreatment immediately.</p> <p>The facility's failure to ensure staff reported observed incidents of abuse to the Administration immediately has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 05/01/14 and determined to exist on 04/07/14. The facility was notified of the Immediate Jeopardy on 05/01/14.</p>	F 225	<p>5/2/14, and LPN, on 5/2/14, identified in the allegation, pending investigation. Both were terminated, on 5/8/14 as a result of the investigation findings.</p> <p>-Resident #4 was assessed by the DON on 5/1/14 for any signs/symptoms of injury or distress, with none identified.</p> <p>-The MD and responsible party for resident #4 were notified of the allegation of abuse, the reporting of the allegation to the required authorities, and that an investigation was underway on 5/2/14.</p> <p>Criteria2: -The ADON conducted physical assessments on all of the non-interviewable Infirmary residents on 4/8/14 and 5/2/14 for signs/symptoms of injury/possible abuse, and conducted interviews on 4/8/14 and 5/2/14 of all interviewable residents (BIMS score of 9 or higher), with no injuries or allegations noted or reported.</p> <p>-The Care Plans and C.N.A Care Plans</p>	

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F 225	Continued From page 22 The findings include: Review of the facility's "Resident Safe Environment" policy and procedures, (not dated), revealed each resident has the right to be free from verbal, physical, sexual, and mental harassment or abuse. The policy included the following definitions: Abuse- the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish; Verbal Abuse - any use of oral, gestured, language that includes disparaging and derogatory terms to residents regardless of their ability to comprehend; Physical Abuse - as controlling behavior through corporal punishment; and Mental Abuse: as harassment, threats of punishment or deprivation. Any alleged incidents of abuse, neglect, or exploitation must be reported immediately to the appropriate supervisor; the Administrator of the facility must be immediately notified. 1. Record review revealed the facility admitted Resident #1, on 05/09/13, with diagnoses which included Alzheimer's Disease, Hypertension and Anxiety. Review of the cellular phone video recording, on 04/29/14 at 9:37 AM, revealed on 04/07/14 at approximately 3:00 AM, Resident #1 was sitting at the Nurse's Station with over the bed tables placed around him/her to prevent him/her from wandering. LPN #1 kept telling Resident #1 to "sit down" in a commanding voice and called Resident #1 "a brat", the LPN was exhibiting this behavior for four (4) minutes. Resident #1 could be heard crying. Further review revealed two (2) other staff members (CNA #1 and CNA #2), who were partially visible; and the voice of CNA #3	F 225	for all Infirmiry residents were reviewed/revised by the MDS Coordinator and QA Nurse to determine that they reflected resident behaviors and the appropriate interventions for staff to manage the behaviors, as completed by 5/2/14. Criteria 3: -Inservice education was provided for all staff on the abuse policy components, the types of abuse, the need to protect the resident and report abuse immediately, and how to recognize signs/symptoms of staff burnout on 4/11, 4/14, and 5/5 by the ADON. A post-test was provided at the conclusion of the inservice training on 5/5/14 to verify staff comprehension of the training information. Any staff not meeting the threshold of 100% were re-educated until this threshold was met. -All staff who were not present at the inservice training on 5/5/14 were prevented from working until completion of the training and the post-test, by the removal		

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F 225	<p>Continued From page 23</p> <p>could be heard. The three (3) CNAs observed LPN #1 blocking Resident #1 in the Nurse's Station and heard the verbal remarks made to Resident #1 by LPN #1; however, no one immediately reported this to Administration.</p> <p>Interviews on 04/29/14 at 2:45 PM and 3:10 PM; and, on 04/30/14 at 9:05 AM respectively, with CNA #1, CNA #2, and CNA #3 revealed LPN #1 was blocking the resident in the Nurse's Station with over the bed tables so the resident could not wander on 04/07/14. CNA #1 and CNA #3 further stated the LPN was calling Resident #1 "a brat" and told the resident repeatedly to "sit down". All three (3) CNAs stated they were intimidated by LPN #1, as she treated them like she was a "Drill Sergeant". The CNAs stated LPN #1 had them sit with Resident #1 and block him/her from walking freely on numerous occasions. They stated they feared LPN #1 would retaliate if they reported any of the incidents. CNA #1 stated she waited until the LPN was not in the building then reported the incident to the DON.</p> <p>2. Record review revealed the facility admitted Resident #4 on 01/20/14 with diagnoses which included Advanced Age with Dementia, Combativeness, and Depression.</p> <p>Interview, on 05/06/14 at 3:47 PM with CNA #5, revealed she witnessed CMT #1 and LPN #3 mistreat Resident #4 on 05/01/14 around 7:30 PM. CNA #5 stated she saw CMT #1 grasp Resident #1's hands tightly and cross them across the resident's lap as LPN #1 pulled his/her wheelchair backwards down the hallway taking Resident #1 into his/her room. CNA #5 stated she saw CMT #1 roughly remove Resident #1's sweater and pull the wheelchair from under</p>	F 225	<p>of their time cards.</p> <p>Criteria 4: -The abuse allegation events, the investigation, and the action plan were reviewed with the Medical Director in a QA meeting conducted on 5/5/14.</p> <p>-The CQI indicator for the monitoring of compliance with the abuse regulations will be utilized with any allegation that occurs for the next 2 months, then monthly X 6 months beginning within one month from 5/6/14, and then quarterly thereafter under the supervision of the DON. This tool reviews compliance with the interventions required by the regulation for an allegation of abuse, including but not limited to: reporting, protecting the resident, investigating, and notifying.</p> <p>-Results of the audits are reported to the QA Committee by the DON quarterly, with the most recent meeting taking place on 6/3/14. If an accepted threshold of compliance, as referenced on the CQI tool, is</p>		

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F 225	<p>Continued From page 24</p> <p>Resident#1 causing the resident to be suspended above the fall mat in his/her room. In addition, CNA #5 stated CMT #1 roughly lifted Resident #1 from the wheelchair and "flung" him/her on the side of the bed. CNA #5 stated she did not report the incident to the administration of the facility until the end of the shift at 10:30 PM. The CNA stated she was waiting for LPN #3 to report the incident but when the LPN had not reported the incident by the end of the shift, she called the DON.</p> <p>Interview, on 05/07/14 at 1:50 PM with LPN #3, revealed on 05/01/14 at 7:30 PM she saw Resident #4 in the wrong room going through another resident's drawers. The LPN stated she redirected the resident but the resident began screaming. LPN #3 revealed CMT #1 then came up to the resident and "pried the resident's hands off the wheels of the wheelchair, grasped them tightly and crossed them across the resident's lap." Further interview with LPN #3 revealed she pulled Resident #4 backwards down the hallway into Resident #4's room. LPN #3 stated CMT #1 then pulled Resident #4's sweater off over his/her head roughly and lifted the resident and put him/her on the bedside. The LPN stated "It was shift change before I realized it and I did not report the incident."</p> <p>Interview with the Administrator and DON, on 04/29/14 at 9:37 AM and on 05/06/14 at 2:45 PM, revealed the staff who witnessed these incidents should have reported the mistreatment of the residents to Administration immediately.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p>	F 225	<p>not achieved, the DON shall develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next scheduled meeting.</p> <p>-Staff were questioned as chosen randomly on the abuse policy components weekly X 2 weeks as completed by the ADON beginning on 5/5/14.</p> <p>-The completed CQI indicators for the monitoring of compliance with the abuse regulations, and any action plans developed related to these indicators, will be reviewed by the Nurse Consultant with monthly visits.</p> <p>Criteria 5:</p>	<p>June 4 2014</p>	

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F 225	<p>Continued From page 25</p> <p>On 04/08/14, the facility suspended, then terminated LPN #1. The incident involving LPN #1 was then reported to the Kentucky Board of Nursing by the facility's DON.</p> <p>On 04/08/14 and 05/05/14, the Assistant Director of Nursing (ADON) conducted physical assessments on all the non-interviewable residents for signs/symptoms of possible abuse and interviews on all interviewable residents; no injuries were found. Further on 05/02/14, the ADON conducted interviews on all interviewable residents (those with a Brief Interview for Mental Status (BIMS) score of nine (9) or higher to identify concerns related to care or any staff member, or events involving possible mistreatment by the staff or others with no concerns identified. The Nurse Care Plans for all residents were reviewed and updated with focus on interventions specific to the resident's behaviors.</p> <p>The facility began interviewing employees on 04/08/14 and repeated the interviews on 05/05/14 as education and re-education and training as part of their in-service training on the facility's abuse policy. Time cards were removed from the clock-in area and were not issued to the employees until the re-education was completed.</p> <p>Quality Assurance (QA) monitors began on 05/05/14 and included all facility staff and Continuous Quality Improvement (CQI) indicators for monitoring compliance with Care Planning to be conducted monthly for six (6) months beginning one month from 05/06/14 then quarterly thereafter under the supervision of the DON. Audits to be reported to the QA committee and a threshold of compliance is referenced as</p>	F 225		

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F 225	<p>Continued From page 26</p> <p>no abusive situations or reports. Compliance rounds are to be conducted weekly by the Administrator nursing staff to ensure compliance with resident care interventions being provided in accordance with the care plan.</p> <p>The State Agency validated the Corrective Action taken by the facility as follows:</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she was aware the Director of Nursing (DON) reported LPN #1's abusive behavior to the Kentucky Board of Nursing (KBN) on 05/02/14.</p> <p>Further interview on 05/22/14 at 4:00 PM with the Administrator revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14; LPN #3 is not eligible for rehire. CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility according to the Administrator.</p> <p>Additionally, interview on 05/22/14 at 4:00 PM with the Administrator revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administrator in a timely manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Interview on 05/22/14 at 4:30 PM with the Assistant Director of Nursing (ADON) revealed she was aware the DON reported LPN #1's abusive behavior to the KBN on 05/02/14.</p>	F 225			

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F 225	<p>Continued From page 27</p> <p>Further interview on 05/22/14 at 4:30 PM with the ADON revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14 and is not eligible for rehire; further CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility.</p> <p>Additionally, interview on 05/22/14 at 4:30 PM with the ADON revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administration in a timely manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Record review on 05/22/14 at 5:10 PM revealed an Employee Exit Interview dated 04/16/14 that shows LPN #1 was terminated on 04/16/14 and is not eligible for rehire. Further record review revealed LPN #3 and CMT #1 were suspended on 05/01/14 and 05/02/14 respectively, and then employment from the facility was terminated on 05/12/14 and neither are eligible for rehire at the facility. Additionally; CNA #1, CNA #2, CNA #3 received final written warnings and any future infraction will result in termination of employment at the facility, CNA #5 received counseling related to the reporting of abuse, neglect or mistreatment of residents to administration immediately.</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she had oversight and that the ADON had conducted physical assessments and individually interviewed all</p>	F 225			

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F 225	<p>Continued From page 28</p> <p>residents of the Skilled Nursing Facility (SNF) on 04/08/14 and no findings of abuse were identified. Additionally she stated the ADON conducted mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p> <p>Interview on 05/22/14 at 4:30 PM with the ADON revealed she conducted physical assessments and individually interviewed all residents of the SNF on 04/08/14 and no findings of abuse were identified. Additionally she states she conducted mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p> <p>Record review on 05/12/14 at 3:00 PM revealed the physical assessments and the interviews with all residents of the SNF were conducted and recorded by the ADON and that no concerns were identified.</p> <p>Interview on 05/07/14 at 8:15 AM with the MDS Coordinator, who is a Registered Nurse (RN) revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the "Sisters".</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the</p>	F 225		

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F 225	<p>Continued From page 29</p> <p>in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters, further stating the abuse hotline number was posted beside the time clock.</p> <p>Interview on 05/07/14 at 8:40 AM with a Housekeeper revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14. Her signature was noted on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go higher up or notify the DON or one of the Sisters.</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/22/14 at 5:29 PM with RN #2 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or</p>	F 225		

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F 225	<p>Continued From page 30</p> <p>Administrator immediately, if the incident involved a superior she would go to a higher up and notify the DON or one of the Sisters. She stated the primary concern was to keep the resident safe and remove the alleged perpetrator from the building immediately, "it's not just that we hear about abuse and have inservices on them, if you have a gut feeling something is wrong you do something about it."</p> <p>Interview on 05/07/14 at 5:45 PM with CNA #12 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" , or notify the DON or one of the Sisters. She further stated, "We have in-services and meetings frequently it seems, several times since I came seven (7) months ago, it's like fire and severe weather drills you should know what to do, wrong is wrong, report it immediately. Go to a nurse, if it's a nurse call the ADON or the DON and there's the numbers by the time clock for the Hotline if you need it."</p> <p>Interview on 05/22/14 at 5:50 PM with CMT #2 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON, or one of</p>	F 225		

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F 225	<p>Continued From page 31 the Sisters.</p> <p>Interview on 05/22/14 at 6:00 PM with CNA #11 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety, abuse or mistreatment of any kind to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would call the DON or one of the Sisters. She further stated they gave us all a sheet with their numbers on it so we can call them anytime we need to, as well. The Sisters have beepers if we need them.</p> <p>Interview on 05/07/14 at 6:05 PM with CNA #13 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/07/14 at 6:15 PM with a Dietary Staff Member revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of</p>	F 225		

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F 225	<p>Continued From page 32 the Sisters.</p> <p>Interview on 05/06/14 at 3:45 PM with the DON revealed she assigned the MDS Coordinator to review all residents' care plans on 04/11/14 and 05/05/14 for appropriateness, applicable problems, goals and interventions or approaches. The Nurse's Care Plans were reviewed and updated every quarter according to the resident's date their Minimum Data Set (MDS) was completed.</p> <p>Interview on 05/06/14 at 2:40 PM with the MDS Coordinator/RN revealed she conducted the review and update of the care plans. She stated usually this was an ongoing process, "I am out here with the residents and staff talking to the residents and we all talk about what is appropriate for whom and I update the care plans every third month, they reflect the MDS, and the CNA's care plan reflects the Nurse's Care Plan. We all give input and if we see any inconsistencies with the resident's ability we notify Sister, the ADON.</p> <p>Interview on 05/12/14 at 2:40 PM with LPN #2 revealed she was familiar with the review and update of the care plans. She stated the MDS Coordinator usually updates them every month. LPN #2 stated the MDS Coordinator was out on the Unit talking to the residents and staff.</p> <p>Interview on 05/12/14 at 4:55 PM with RN #1 revealed she recalled all staff was verbally reminded of the importance of following each resident's care plan. An example was voiced of walking with the resident if that is what the care plan indicated, if we don't see that it is followed we are not doing the right nursing care. As an</p>	F 225		

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F 225	<p>Continued From page 33</p> <p>RN, "I must see that the care plans are followed for the resident's well being."</p> <p>Interview on 05/22/14 at 5:29 PM with RN #2 revealed she has worked in the facility for one (1) month and was familiar with the review and update of the care plans. She stated the MDS Coordinator usually does that every so often. She further stated the MDS Coordinator was out on the Unit talking to the residents and staff. We all give input and if we see any inconsistencies we notify "Sister, the ADON".</p> <p>Review on 04/30/14 at 4:00 PM revealed in-service logs entitled "Resident safe Environment" and staff roster with signatures indicating attendance, dated 04/11/14. This inservice covered wheelchair safety, stress, burn-out, coping, gait belt use, oral care, cell phone use; and, abuse inservice signatures which indicated ninety- four (94) staff members attended the in-service between 04/11/14 and 04/14/14.</p> <p>Review on 05/12/14 of the in-service logs, dated 05/05/14, revealed all staff was inserviced related to abuse, neglect, recognizing and reporting signs of stress and burn-out, and following the plan of care.</p> <p>On 05/12/14 at 2:10 PM, CNA #9 verified through interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p> <p>Interview on 05/12/14 at 2:17 PM with CNA #10; and at 2:40 PM with LPN #4, revealed they had received the in-service education on 05/02/14 by</p>	F 225			

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F 225	<p>Continued From page 34</p> <p>the ADON and they were aware of the signs/symptoms of abuse. The training also included to report to a supervisor immediately any allegation or witnessed abusive situations and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer.</p> <p>On 05/12/14 at 2:45 PM, a housekeeper verified through interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p> <p>On 05/12/14 at 4:55 PM, RN #1; on 05/22/14 at 5:29 PM with RN #2, and at 5:50 PM with CMT #2 verified through interview that they had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings. The inservice also included caregiver stress and signs of burn-out, and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer.</p> <p>Interview on 05/22/14 at 5:55 PM with CNA #11 revealed she had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to call on one of the Nuns even to the point of interrupting prayer. She stated, "I would get a Sister because I feel like we should treat these people like they are our grandparents and you want your grandparents treated well."</p> <p>On 05/22/14 at 5:45 PM, CNA #12 verified through interview that she had received the</p>	F 225		

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F 225	<p>Continued From page 35</p> <p>inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to call on one of the nuns even to the point of interrupting prayer."If it's wrong it's wrong, you can't let somebody get away with treating somebody mean you got to tell someone."</p> <p>Record review on 05/22/14 at 6:00 PM revealed the abuse allegations, the investigations, and the action plan was reviewed. Further review of a form entitled Continuous Quality Improvement; the Indicator: Knowledge and Compliance of Abuse and Reporting Policy; Recognizing Stress and Burn-out revealed one-hundred-seven (107) [all the facility staff] staff members received the re-education and in-service training and signed the rosters, their time-cards were held until their signatures were obtained in statement of participation. Through explanation by the ADON, random employees were asked Criteria/Question such as: stating the chain of command, know when to report, Identifies signs/symptoms of self stress and self burnout, names of coping strategies, know where to find contact numbers for reporting abuse. Each department will conduct these compliance rounds weekly and calculate the percentage of compliance. This will be conducted under the supervision of the DON and results will be reported to the QA committee. If an acceptable threshold of compliance is not achieved the DON will develop and oversee a corrective action. Compliance rounds are conducted weekly by the Administrative nursing staff to determine that resident care interventions are being provided in accordance with the care</p>	F 225			

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F 225	Continued From page 36 plan.	F 225			
F 226 SS=J	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of a video recording and the facility's policy and procedure it was determined the facility failed to ensure staff implemented the facility's "Resident Safe Environment" policy and procedure for two (2) of nine (9) sampled residents (Resident #1 and Resident #4).</p> <p>Review of a cellular telephone video recording revealed on 04/07/14 at approximately 3:00 AM, Licensed Practical Nurse (LPN) #1 had Resident #1 sitting at the Nurse's Station with three (3) over the bed tables placed around the resident to prevent him/her from wandering. LPN #1 was calling Resident #1 "a brat", pointing and shaking her finger at the resident and talking to the</p>	F 226			

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F 226	<p>Continued From page 37</p> <p>resident in a commanding voice. Resident #1 was audibly crying. Further review revealed three (3) other staff, Certified Nurse Aides (CNA) #1, CNA #2 and CNA #3 witnessed the incident. However, the CNAs failed to report the mistreatment to Administration immediately per the facility's policy and procedure.</p> <p>Additionally, on 05/01/14 at 7:30 PM, CNA #5 observed Certified Medication Technician (CMT#1) grab Resident #4's hands tightly and hold the resident's hands in his/her lap. CMT #1 and LPN #3 then wheeled the resident backwards down the hallway to the resident's room in a wheelchair. Once in the room, CMT #1 removed Resident #4's sweater roughly and then pulled the wheelchair from under Resident #4 causing him/her to be suspended above the fall mat in his/her room. CMT #1 then roughly lifted Resident #4 from the wheelchair and "flung" him/her on the side of the bed. LPN #3 and CNA #5 both observed CMT #5's mistreatment of Resident #4. However, they failed to report the mistreatment to Administration immediately per the facility's policy and procedure.</p> <p>The facility's failure to ensure staff reported observed incidents of abuse to the Administration immediately has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 05/01/14 and determined to exist on 04/07/14. The facility was notified of the Immediate Jeopardy on 05/01/14.</p> <p>The findings include:</p> <p>Review of the facility's "Resident Safe Environment" policy and procedures, (not dated),</p>	F 226	<p>Criteria 1: -Upon notification of the allegation of abuse regarding resident #1, the ADM suspended the LPN identified in the allegation, on 4/8/14. The LPN was terminated on 4/11/14, and the event reported to the KBN.</p> <p>-Resident #1 was assessed by the ADON on 4/8/14 for any signs/symptoms of injury or distress, with none identified.</p> <p>-The MD and responsible party for Resident #1 were notified of the allegation of abuse, the reporting of the allegation to the required authorities, and that an investigation was underway on 4/8/14.</p> <p>-Upon notification of the allegation of abuse regarding resident # 4, the DON suspended the CMT, on 5/2/14, and LPN, on 5/1/14, identified in the allegation, pending investigation. Both were terminated as a result of the investigation findings.</p> <p>-Resident #4 was assessed by the DON on 5/1/14 for any signs/symptoms of injury</p>	

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F 226	<p>Continued From page 38</p> <p>revealed each resident has the right to be free from verbal, physical, sexual, and mental harassment or abuse. The policy included the following definitions: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish; Verbal Abuse - any use of oral, gestured, language that includes disparaging and derogatory terms to residents regardless of their ability to comprehend; Physical Abuse - as controlling behavior through corporal punishment; and Mental Abuse: as harassment, threats of punishment or deprivation. Any alleged incidents of abuse, neglect, or exploitation must be reported immediately to the appropriate supervisor; the Administrator of the facility must be immediately notified.</p> <p>1. Record review revealed the facility admitted Resident #1 on 05/09/13 with diagnoses which included Alzheimer's Disease, Hypertension, and Anxiety.</p> <p>Review of the cell phone video recording, on 04/29/14 at 9:37 AM, revealed on 04/07/14 at approximately 3:00 AM, LPN #1 and Resident #1 were sitting in the Nurse's Station and there were over the bed tables placed around the resident to prevent him/her from wandering. LPN #1 was telling Resident #1 to "sit down" repeatedly in a commanding voice and she was calling Resident #1 "a brat". Resident #1 could be heard crying. Further review revealed two (2) other staff members (CNA #1 and CNA #2), who were partially visible; and the voice of a third staff member identified by the Director of Nursing as CNA #3. The three (3) CNAs observed LPN #1 blocking Resident #1 in the Nurse's Station and heard the verbal remarks made to Resident #1 by</p>	F 226	<p>or distress, with none identified.</p> <p>-The MD and responsible party for resident #4 were notified of the allegation of abuse, the reporting of the allegation to the required authorities, and that an investigation was underway on 5/2/14.</p> <p>Criteria 2: -The ADON conducted physical assessments on all of the non-interviewable Infirmary residents on 4/8/14 and 5/2/14 for signs/symptoms of injury/possible abuse, and conducted interviews on 4/8/14 and 5/2/14 of all interviewable residents (BIMS score of 9 or higher), with no injuries or allegations noted or reported.</p> <p>-The Care Plans and C.N.A Care Plans for all Infirmary residents were reviewed/revised by the MDS Coordinator and QA Nurse to determine that they reflected resident behaviors and the appropriate interventions for staff to manage the behaviors, as completed by 5/2/14.</p>		

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F 226	<p>Continued From page 39</p> <p>LPN #1. However, no one reported the incident to the Administrator, as per policy.</p> <p>Interview with CNA #1, CNA #2 and CNA #3, on 04/29/14 at 2:45 PM and 3:10 PM; and, on 04/30/14 at 9:05 AM respectively, revealed the CNAs were intimidated by the LPN and she treated them like she was a "Drill Sergeant". The CNAs stated they did not report any of the incidents because of fear of retaliation by the LPN. CNA #1 stated she waited and reported the incident on 04/08/14 when the LPN was not at work.</p> <p>2. Record review revealed the facility admitted Resident #4 on 01/20/14 with diagnoses which included Advanced Age with Dementia, Gastro-Intestinal Bleed, Anemia, Hemorrhoids, Combativeness and Depression.</p> <p>Interview, on 05/06/14 at 3:47 PM with CNA #5, revealed on 05/01/14 around 7:30 PM, she witnessed CMT #1 grab Resident #1's hands tightly and cross the resident's hands across his/her lap as LPN #1 pulled his/her wheelchair backwards down the hallway taking Resident #1 into his/her room. CNA #5 stated CMT #1 roughly removed the resident's sweater and pulled the wheelchair from under Resident #1 causing the resident to be suspended above the fall mat in his/her room. In addition, CNA #5 stated CMT #1 roughly lifted Resident #1 from the wheelchair and "flung" him/her on the side of the bed. CNA #5 stated she did not report the incident to Administration immediately per the facility's policy and procedure, but she reported it at the end of the shift at 10:30 PM. The CNA stated she waited for LPN #3 to report the mistreatment but when the LPN had not reported it by the end of</p>	F 226	<p>Criteria 3: -Inservice education was provided for all staff on the abuse policy components, the types of abuse, the need to protect the resident and report abuse immediately, and how to recognize signs/symptoms of staff burnout on 4/11, 4/14, and 5/5 by the ADON. A post test was provided at the conclusion of the inservice training on 5/5/14 to verify staff comprehension of the training information. Any staff not meeting the threshold of 100% were re-educated until this threshold was met.</p> <p>-All staff who were not present at the inservice training on 5/5/14 were prevented from working until completion of the training and the post test, by the removal of their time cards.</p> <p>Criteria 4: -The abuse allegation events, the investigation, and the action plan were reviewed with the Medical Director in a QA meeting conducted on 5/5/14.</p> <p>-The CQI indicator for the monitoring of compliance</p>		

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F 226	<p>Continued From page 40 the shift, she called the DON.</p> <p>Interview, on 05/07/14 at 1:50 PM with LPN #3, revealed on 05/01/14 at 7:30 PM she had observed CMT #1 "pry the resident's hands off the wheels of the wheelchair, grasp them tightly and cross them across the resident's lap." The LPN stated she pulled Resident #4 backwards down the hallway and into his/her room. LPN #3 stated she then observed CMT #1 pull Resident #4's sweater off over his/her head roughly and lift the resident and put him/her on the bedside. The LPN stated the facility's policy was to report immediately but, "It was shift change before I realized it and I did not report the incident."</p> <p>Interview with the Administrator and DON, on 04/29/14 at 9:37 AM and on 05/06/14 at 2:45 PM, revealed all staff had been educated on the "Resident Safe Environment" policy and the staff who witnessed these incidents should have reported the mistreatment of the residents to the Administration immediately, as per facility policy.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 04/08/14, the facility suspended, then terminated LPN #1. The incident involving LPN #1 was then reported to the Kentucky Board of Nursing by the facility's DON.</p> <p>On 04/08/14 and 05/05/14, the Assistant Director of Nursing (ADON) conducted physical assessments on all the non-interviewable residents for signs/symptoms of possible abuse and interviews on all interviewable residents; no injuries were found. Further on 05/02/14, the ADON conducted interviews on all interviewable</p>	F 226	<p>with the abuse regulations will be utilized with any allegation that occurs for the next 2 months, then monthly X 6 months beginning within one month from 5/6/14, and then quarterly thereafter under the supervision of the DON. This tool reviews compliance with the interventions required by the regulation for an allegation of abuse, including but not limited to: reporting, protecting the resident, investigating, and notifying.</p> <p>-Results of the audits are reported to the QA Committee by the DON quarterly, with the most recent meeting taking place on 6/3/14. If an accepted threshold of compliance, as referenced on the CQI tool, is not achieved, the DON shall develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next scheduled meeting.</p> <p>-Staff were questioned as chosen randomly on the abuse policy components weekly X 2 weeks as completed</p>	

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F 226	<p>Continued From page 41</p> <p>residents (those with a Brief Interview for Mental Status (BIMS) score of nine (9) or higher to identify concerns related to care or any staff member, or events involving possible mistreatment by the staff or others with no concerns identified. The Nurse Care Plans for all residents were reviewed and updated with focus on interventions specific to the resident's behaviors.</p> <p>The facility began interviewing employees on 04/08/14 and repeated the interviews on 05/05/14 as education and re-education and training as part of their in-service training on the facility's abuse policy. Time cards were removed from the clock-in area and were not issued to the employees until the re-education was completed.</p> <p>Quality Assurance (QA) monitors began on 05/05/14 and included all facility staff and Continuous Quality Improvement (CQI) indicators for monitoring compliance with Care Planning to be conducted monthly for six (6) months beginning one month from 05/06/14 then quarterly thereafter under the supervision of the DON. Audits to be reported to the QA committee and a threshold of compliance is referenced as no abusive situations or reports. Compliance rounds are to be conducted weekly by the Administrator nursing staff to ensure compliance with resident care interventions being provided in accordance with the care plan.</p> <p>The State Agency validated the Corrective Action taken by the facility as follows:</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she was aware the Director of Nursing (DON) reported LPN #1's</p>	F 226	<p>by the ADON beginning on 5/5/14.</p> <p>-The completed CQI indicators for the monitoring of compliance with the abuse regulations, and any action plans developed related to these indicators, will be reviewed by the Nurse Consultant with monthly visits.</p> <p>Criteria 5:</p>	June 4 2014

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F 226	<p>Continued From page 42</p> <p>abusive behavior to the Kentucky Board of Nursing (KBN) on 05/02/14.</p> <p>Further interview on 05/22/14 at 4:00 PM with the Administrator revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14; LPN #3 is not eligible for rehire. CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility according to the Administrator.</p> <p>Additionally, interview on 05/22/14 at 4:00 PM with the Administrator revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administrator in a timely manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Interview on 05/22/14 at 4:30 PM with the Assistant Director of Nursing (ADON) revealed she was aware the DON reported LPN #1's abusive behavior to the KBN on 05/02/14.</p> <p>Further interview on 05/22/14 at 4:30 PM with the ADON revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14 and is not eligible for rehire; further CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility.</p> <p>Additionally, interview on 05/22/14 at 4:30 PM</p>	F 226			

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F 226	<p>Continued From page 43</p> <p>with the ADON revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administration in a timely manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Record review on 05/22/14 at 5:10 PM revealed an Employee Exit Interview dated 04/16/14 that shows LPN #1 was terminated on 04/16/14 and is not eligible for rehire. Further record review revealed LPN #3 and CMT #1 were suspended on 05/01/14 and 05/02/14 respectively, and then employment from the facility was terminated on 05/12/14 and neither are eligible for rehire at the facility. Additionally; CNA #1, CNA #2, CNA #3 received final written warnings and any future infraction will result in termination of employment at the facility, CNA #5 received counseling related to the reporting of abuse, neglect or mistreatment of residents to administration immediately.</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she had oversight and that the ADON had conducted physical assessments and individually interviewed all residents of the Skilled Nursing Facility (SNF) on 04/08/14 and no findings of abuse were identified. Additionally she stated the ADON conducted mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p> <p>Interview on 05/22/14 at 4:30 PM with the ADON revealed she conducted physical assessments and individually interviewed all residents of the SNF on 04/08/14 and no findings of abuse were identified. Additionally she states she conducted</p>	F 226		

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F 226	<p>Continued From page 44</p> <p>mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p> <p>Record review on 05/12/14 at 3:00 PM revealed the physical assessments and the interviews with all residents of the SNF were conducted and recorded by the ADON and that no concerns were identified.</p> <p>Interview on 05/07/14 at 8:15 AM with the MDS Coordinator, who is a Registered Nurse (RN) revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the "Sisters".</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters, further stating the abuse hotline number was posted beside the time clock.</p> <p>Interview on 05/07/14 at 8:40 AM with a Housekeeper revealed she received in-service training on abuse/neglect and reporting to</p>	F 226		

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F 226	<p>Continued From page 45</p> <p>Administration on 05/05/14. Her signature was noted on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go higher up or notify the DON or one of the Sisters.</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/22/14 at 5:29 PM with RN #2 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or Administrator immediately, if the incident involved a superior she would go to a higher up and notify the DON or one of the Sisters. She stated the primary concern was to keep the resident safe and remove the alleged perpetrator from the building immediately, "it's not just that we hear about abuse and have inservices on them, if you have a gut feeling something is wrong you do something about it."</p> <p>Interview on 05/07/14 at 5:45 PM with CNA #12 revealed she received in-service training on</p>	F 226		

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F 226	<p>Continued From page 46</p> <p>abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" , or notify the DON or one of the Sisters. She further stated, "We have in-services and meetings frequently it seems, several times since I came seven (7) months ago, it's like fire and severe weather drills you should know what to do, wrong is wrong, report it immediately. Go to a nurse, if it's a nurse call the ADON or the DON and there's the numbers by the time clock for the Hotline if you need it."</p> <p>Interview on 05/22/14 at 5:50 PM with CMT #2 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON, or one of the Sisters.</p> <p>Interview on 05/22/14 at 6:00 PM with CNA #11 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety, abuse or mistreatment of any kind to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would call the DON or one of the</p>	F 226		

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F 226	<p>Continued From page 47</p> <p>Sisters. She further stated they gave us all a sheet with their numbers on it so we can call them anytime we need to, as well. The Sisters have beepers if we need them.</p> <p>Interview on 05/07/14 at 6:05 PM with CNA #13 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/07/14 at 6:15 PM with a Dietary Staff Member revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/06/14 at 3:45 PM with the DON revealed she assigned the MDS Coordinator to review all residents' care plans on 04/11/14 and 05/05/14 for appropriateness, applicable problems, goals and interventions or approaches. The Nurse's Care Plans were reviewed and updated every quarter according to the resident's date their Minimum Data Set (MDS) was completed.</p>	F 226		

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F 226	<p>Continued From page 48</p> <p>Interview on 05/06/14 at 2:40 PM with the MDS Coordinator/RN revealed she conducted the review and update of the care plans. She stated usually this was an ongoing process, "I am out here with the residents and staff talking to the residents and we all talk about what is appropriate for whom and I update the care plans every third month, they reflect the MDS, and the CNA's care plan reflects the Nurse's Care Plan. We all give input and if we see any inconsistencies with the resident's ability we notify Sister, the ADON.</p> <p>Interview on 05/12/14 at 2:40 PM with LPN #2 revealed she was familiar with the review and update of the care plans. She stated the MDS Coordinator usually updates them every month. LPN #2 stated the MDS Coordinator was out on the Unit talking to the residents and staff.</p> <p>Interview on 05/12/14 at 4:55 PM with RN #1 revealed she recalled all staff was verbally reminded of the importance of following each resident's care plan. An example was voiced of walking with the resident if that is what the care plan indicated, if we don't see that it is followed we are not doing the right nursing care. As an RN, "I must see that the care plans are followed for the resident's well being."</p> <p>Interview on 05/22/14 at 5:29 PM with RN #2 revealed she has worked in the facility for one (1) month and was familiar with the review and update of the care plans. She stated the MDS Coordinator usually does that every so often. She further stated the MDS Coordinator was out on the Unit talking to the residents and staff. We all give input and if we see any inconsistencies we notify "Sister, the ADON".</p>	F 226			

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F 226	<p>Continued From page 49</p> <p>Review on 04/30/14 at 4:00 PM revealed in-service logs entitled "Resident safe Environment" and staff roster with signatures indicating attendance, dated 04/11/14. This inservice covered wheelchair safety, stress, burn-out, coping, gait belt use, oral care, cell phone use; and, abuse inservice signatures which indicated ninety- four (94) staff members attended the in-service between 04/11/14 and 04/14/14.</p> <p>Review on 05/12/14 of the in-service logs, dated 05/05/14, revealed all staff was inserviced related to abuse, neglect, recognizing and reporting signs of stress and burn-out, and following the plan of care.</p> <p>On 05/12/14 at 2:10 PM, CNA #9 verified through interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p> <p>Interview on 05/12/14 at 2:17 PM with CNA #10; and at 2:40 PM with LPN #4, revealed they had received the in-service education on 05/02/14 by the ADON and they were aware of the signs/symptoms of abuse. The training also included to report to a supervisor immediately any allegation or witnessed abusive situations and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer.</p> <p>On 05/12/14 at 2:45 PM, a housekeeper verified through interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p>	F 226		

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F 226	Continued From page 50 On 05/12/14 at 4:55 PM, RN #1; on 05/22/14 at 5:29 PM with RN #2, and at 5:50 PM with CMT #2 verified through interview that they had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings. The inservice also included caregiver stress and signs of burn-out, and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer. Interview on 05/22/14 at 5:55 PM with CNA #11 revealed she had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to call on one of the Nuns even to the point of interrupting prayer. She stated, "I would get a Sister because I feel like we should treat these people like they are our grandparents and you want your grandparents treated well." On 05/22/14 at 5:45 PM, CNA #12 verified through interview that she had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to call on one of the nuns even to the point of interrupting prayer."If it's wrong it's wrong, you can't let somebody get away with treating somebody mean you got to tell someone." Record review on 05/22/14 at 6:00 PM revealed	F 226			

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F 226	Continued From page 51 the abuse allegations, the investigations, and the action plan was reviewed. Further review of a form entitled Continuous Quality Improvement; the Indicator: Knowledge and Compliance of Abuse and Reporting Policy; Recognizing Stress and Burn-out revealed one-hundred-seven (107) [all the facility staff] staff members received the re-education and in-service training and signed the rosters, their time-cards were held until their signatures were obtained in statement of participation. Through explanation by the ADON, random employees were asked Criteria/Question such as: stating the chain of command, know when to report, Identifies signs/symptoms of self stress and self burnout, names of coping strategies, know where to find contact numbers for reporting abuse. Each department will conduct these compliance rounds weekly and calculate the percentage of compliance. This will be conducted under the supervision of the DON and results will be reported to the QA committee. If an acceptable threshold of compliance is not achieved the DON will develop and oversee a corrective action. Compliance rounds are conducted weekly by the Administrative nursing staff to determine that resident care interventions are being provided in accordance with the care plan. Interview on 05/22/14 at 6:15 PM with the Medical Director revealed he was informed of the timing for the QA Committee meetings and he had attended the primary discussion with the Administrator, DON and ADON on 05/06/14. Further interview revealed he felt the facility was taking responsibility and being proactive with the QA plan they have put in place.	F 226			
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282			

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F 282 SS=J	Continued From page 52 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of a cellular telephone video recording and the facility's policy and procedure it was determined the facility failed to follow the written plan of care for one (1) of nine (9) sampled residents (Resident #1). Resident #1 was assessed and care planned for the behavior of wandering. An intervention was in place to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and snack. Review of a video recording revealed on 04/07/14 at approximately 3:00 AM, Licensed Practical Nurse (LPN) #1 was with Resident #1 in the Nurse's Station with three (3) over the bed tables around the resident to prevent him/her from wandering. LPN #1 was calling Resident #1 "a Brat", and speaking to the resident in a commanding tone and Resident #1 was crying. Further review of the video revealed no evidence the resident was offered any diversions, activities, food, conversation, television and/or a book. The facility's failure to ensure staff followed the resident's written plan of care has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 05/01/14 and determined to exist on	F 282	Criteria #1 -The care plan and C.N.A care plans for residents #1 and #4 were reviewed by the MDS Coordinator and QA Nurse to determine that they addressed all resident care including but not limited to the resident behaviors and interventions for management of behaviors, as completed by 5/2/14. -Due to the LPN not following resident #1 care plan, and upon notification of the allegations of abuse regarding this resident, the ADM suspended the LPN identified in the allegation on 4/8/14. The LPN was terminated on 4/11/14, and the event reported to the KBN. Due to the CMT and LPN not following resident #4 care plan, and upon notification of the allegations of abuse regarding this resident, the DON suspended the CMT—on 5/2/14 and LPN—on 5/1/14—identified in the allegation of resident #4. Both were terminated, on 5/8/14, as a result of the investigation findings. -Care observations were conducted by the ADON weekly X 3 months to determine		

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F 282	<p>Continued From page 53 04/07/14. The facility was notified of the Immediate Jeopardy on 05/01/14.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 05/09/13 with diagnoses which included Alzheimer's Disease, Hypertension, and Anxiety. Review of the Quarterly Minimum Data Set assessment, dated 12/14/13, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of a three (3), which indicated the resident was not interviewable. Resident #1 exhibited the behavior of wandering.</p> <p>Review of the Comprehensive Care Plan for Elopement Risk/Wandering, dated 06/28/13, revealed interventions to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and/or a book.</p> <p>Review of a video recording, dated 04/07/14 at approximately 3:00 AM, revealed Licensed Practical Nurse (LPN) #1 with Resident #1 in the Nurse's Station with three (3) over the bed tables around the resident to prevent him/her from wandering. LPN #1 could be heard calling Resident #1 "a Brat", and speaking to the resident in a commanding tone. Resident #1 was crying. Further review of the video revealed no evidence staff offered the resident any diversions, activities, food, conversation, television and/or a book, as per the care plan.</p> <p>Interview, on 05/02/14 at 3:38 PM with LPN #1, revealed the resident was care planned to offer diversions. However, she stated, "I thought I was</p>	F 282	<p>that residents # 1 and #4 are provided interventions in accordance with their care plans.</p> <p>Criteria 2: -The care plan and C.N.A care plans for all residents of the Infirmiry were reviewed by the MDS Coordinator and QA Nurse to determine that they addressed resident care including but not limited to resident behaviors and interventions for the management of behaviors, as completed by 5/2/14.</p> <p>-Care observations were conducted by the ADON weekly X 3 months to determine that residents of the Infirmiry are provided care in accordance with their care plans.</p> <p>Criteria #3 -All Infirmiry nursing staff have received inservice education by the ADON on 5/5/14 on the need to provide resident care, including but not limited to behavior management interventions, in accordance with the resident care plans.</p> <p>Criteria #4 -The CQI indicator for the monitoring of resident care provision in accordance with the</p>	

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F 282	<p>Continued From page 54</p> <p>keeping (him/her) safe by making him/her sit down".</p> <p>Interview, on 05/22/14 at 4:55 PM with the ADON, revealed she or the Minimum Data Set (MDS) Coordinator reviewed and updated the Residents' Care Plans monthly, and as needed to ensure up to date Care Planning was completed. Further interview revealed she was on the nursing unit on a daily basis and could verify the Care Plans were followed. Additionally, she stated the CNA Care Plans were updated daily and a paper copy of the daily log was distributed to the staff on duty.</p> <p>Interview, on 04/29/14 at 9:30 AM with the Director of Nursing, revealed she expected staff to follow the residents' care plans. She further stated Resident #1 should have been allowed to walk in the hallways of the Infirmary.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 04/08/14, the facility suspended, then terminated LPN #1. The incident involving LPN #1 was then reported to the Kentucky Board of Nursing by the facility's DON.</p> <p>On 04/08/14 and 05/05/14, the Assistant Director of Nursing (ADON) conducted physical assessments on all the non-interviewable residents for signs/symptoms of possible abuse and interviews on all interviewable residents; no injuries were found. Further on 05/02/14, the ADON conducted interviews on all interviewable residents (those with a Brief Interview for Mental Status (BIMS) score of nine (9) or higher to identify concerns related to care or any staff member, or events involving possible</p>	F 282	<p>care plan will be utilized monthly X 6 months, and then quarterly thereafter beginning within one month from 5/6/14, under the supervision of the DON. This tool reviews compliance by staff with aspects of care including but not limited to: behavioral interventions, safety devices, assistive devices, hygiene etc. The most recent CQI meeting was scheduled to take place on 6/3/14 to review the finding of this CQI indicator.</p> <p>-Care observations are performed on randomly chosen residents weekly X 3 months by the ADON to determine that residents of the Infirmary are provided care in accordance with their care plans.</p> <p>Criteria #5</p>	<p>June 4 2014</p>	

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F 282	<p>Continued From page 55</p> <p>mistreatment by the staff or others with no concerns identified. The Nurse Care Plans for all residents were reviewed and updated with focus on interventions specific to the resident's behaviors.</p> <p>The facility began interviewing employees on 04/08/14 and repeated the interviews on 05/05/14 as education and re-education and training as part of their in-service training on the facility's abuse policy. Time cards were removed from the clock-in area and were not issued to the employees until the re-education was completed.</p> <p>Quality Assurance (QA) monitors began on 05/05/14 and included all facility staff and Continuous Quality Improvement (CQI) indicators for monitoring compliance with Care Planning to be conducted monthly for six (6) months beginning one month from 05/06/14 then quarterly thereafter under the supervision of the DON. Audits to be reported to the QA committee and a threshold of compliance is referenced as no abusive situations or reports. Compliance rounds are to be conducted weekly by the Administrator nursing staff to ensure compliance with resident care interventions being provided in accordance with the care plan.</p> <p>The State Agency validated the Corrective Action taken by the facility as follows:</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she was aware the Director of Nursing (DON) reported LPN #1's abusive behavior to the Kentucky Board of Nursing (KBN) on 05/02/14.</p> <p>Further interview on 05/22/14 at 4:00 PM with the</p>	F 282		

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F 282	<p>Continued From page 56</p> <p>Administrator revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14; LPN #3 is not eligible for rehire. CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility according to the Administrator.</p> <p>Additionally, interview on 05/22/14 at 4:00 PM with the Administrator revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administrator in a timely manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Interview on 05/22/14 at 4:30 PM with the Assistant Director of Nursing (ADON) revealed she was aware the DON reported LPN #1's abusive behavior to the KBN on 05/02/14.</p> <p>Further interview on 05/22/14 at 4:30 PM with the ADON revealed LPN #3 was suspended on 05/01/14 and employment terminated on 05/05/14 as evidenced by an Employee Exit Interview completed by the DON on 05/05/14 and is not eligible for rehire; further CMT #1 was suspended on 05/02/14 and employment terminated on 05/12/14 and she is not eligible for rehire at the facility.</p> <p>Additionally, interview on 05/22/14 at 4:30 PM with the ADON revealed that CNA #1, CNA #2 and CNA #3 received a final written warning on 04/11/14 for failure to report the abusive behavior of LPN #1 to the Administration in a timely</p>	F 282			

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F 282	<p>Continued From page 57</p> <p>manner; further interview revealed that future infractions will result in termination of employment from the facility.</p> <p>Record review on 05/22/14 at 5:10 PM revealed an Employee Exit Interview dated 04/16/14 that shows LPN #1 was terminated on 04/16/14 and is not eligible for rehire. Further record review revealed LPN #3 and CMT #1 were suspended on 05/01/14 and 05/02/14 respectively, and then employment from the facility was terminated on 05/12/14 and neither are eligible for rehire at the facility. Additionally; CNA #1, CNA #2, CNA #3 received final written warnings and any future infraction will result in termination of employment at the facility, CNA #5 received counseling related to the reporting of abuse, neglect or mistreatment of residents to administration immediately.</p> <p>Interview on 05/22/14 at 4:00 PM with the Administrator revealed she had oversight and that the ADON had conducted physical assessments and individually interviewed all residents of the Skilled Nursing Facility (SNF) on 04/08/14 and no findings of abuse were identified. Additionally she stated the ADON conducted mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p> <p>Interview on 05/22/14 at 4:30 PM with the ADON revealed she conducted physical assessments and individually interviewed all residents of the SNF on 04/08/14 and no findings of abuse were identified. Additionally she states she conducted mood and behavior assessments on all the residents of the SNF and no concerns were identified.</p>	F 282		

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F 282	<p>Continued From page 58</p> <p>Record review on 05/12/14 at 3:00 PM revealed the physical assessments and the interviews with all residents of the SNF were conducted and recorded by the ADON and that no concerns were identified.</p> <p>Interview on 05/07/14 at 8:15 AM with the MDS Coordinator, who is a Registered Nurse (RN) revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the "Sisters".</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters, further stating the abuse hotline number was posted beside the time clock.</p> <p>Interview on 05/07/14 at 8:40 AM with a Housekeeper revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14. Her signature was noted on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a nurse, the DON, ADON or</p>	F 282			

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F 282	<p>Continued From page 59</p> <p>Administrator immediately, if the incident involved a superior she would go higher up or notify the DON or one of the Sisters.</p> <p>Interview on 05/07/14 at 8:20 AM with CNA #6 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters.</p> <p>Interview on 05/22/14 at 5:29 PM with RN #2 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to the DON, ADON or Administrator immediately, if the incident involved a superior she would go to a higher up and notify the DON or one of the Sisters. She stated the primary concern was to keep the resident safe and remove the alleged perpetrator from the building immediately, "it's not just that we hear about abuse and have inservices on them, if you have a gut feeling something is wrong you do something about it."</p> <p>Interview on 05/07/14 at 5:45 PM with CNA #12 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for</p>	F 282			

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F 282	<p>Continued From page 60</p> <p>resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" , or notify the DON or one of the Sisters. She further stated, "We have in-services and meetings frequently it seems, several times since I came seven (7) months ago, it's like fire and severe weather drills you should know what to do, wrong is wrong, report it immediately. Go to a nurse, if it's a nurse call the ADON or the DON and there's the numbers by the time clock for the Hotline if you need it."</p> <p>Interview on 05/22/14 at 5:50 PM with CMT #2 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON, or one of the Sisters.</p> <p>Interview on 05/22/14 at 6:00 PM with CNA #11 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety, abuse or mistreatment of any kind to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would call the DON or one of the Sisters. She further stated they gave us all a sheet with their numbers on it so we can call them anytime we need to, as well. The Sisters have beepers if we need them.</p>	F 282			

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F 282	Continued From page 61 Interview on 05/07/14 at 6:05 PM with CNA #13 revealed she received in-service training on abuse/neglect and reporting to Administration on 05/02/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters. Interview on 05/07/14 at 6:15 PM with a Dietary Staff Member revealed she received in-service training on abuse/neglect and reporting to Administration on 05/05/14 as evidenced by her signature on the in-service training roster. Further interview revealed she would report any concerns for resident safety to a Charge Nurse, the DON, ADON or Administrator immediately, if the incident involved a superior she would go "up the chain of command" and notify the DON or one of the Sisters. Interview on 05/06/14 at 3:45 PM with the DON revealed she assigned the MDS Coordinator to review all residents' care plans on 04/11/14 and 05/05/14 for appropriateness, applicable problems, goals and interventions or approaches. The Nurse's Care Plans were reviewed and updated every quarter according to the resident's date their Minimum Data Set (MDS) was completed. Interview on 05/06/14 at 2:40 PM with the MDS Coordinator/RN revealed she conducted the review and update of the care plans. She stated usually this was an ongoing process, "I am out	F 282			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 62</p> <p>here with the residents and staff talking to the residents and we all talk about what is appropriate for whom and I update the care plans every third month, they reflect the MDS, and the CNA's care plan reflects the Nurse's Care Plan. We all give input and if we see any inconsistencies with the resident's ability we notify Sister, the ADON.</p> <p>Interview on 05/12/14 at 2:40 PM with LPN #2 revealed she was familiar with the review and update of the care plans. She stated the MDS Coordinator usually updates them every month. LPN #2 stated the MDS Coordinator was out on the Unit talking to the residents and staff.</p> <p>Interview on 05/12/14 at 4:55 PM with RN #1 revealed she recalled all staff was verbally reminded of the importance of following each resident's care plan. An example was voiced of walking with the resident if that is what the care plan indicated, if we don't see that it is followed we are not doing the right nursing care. As an RN, "I must see that the care plans are followed for the resident's well being."</p> <p>Interview on 05/22/14 at 5:29 PM with RN #2 revealed she has worked in the facility for one (1) month and was familiar with the review and update of the care plans. She stated the MDS Coordinator usually does that every so often. She further stated the MDS Coordinator was out on the Unit talking to the residents and staff. We all give input and if we see any inconsistencies we notify "Sister, the ADON".</p> <p>Review on 04/30/14 at 4:00 PM revealed in-service logs entitled "Resident safe Environment" and staff roster with signatures</p>	F 282			

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

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F 282	<p>Continued From page 63</p> <p>indicating attendance, dated 04/11/14. This inservice covered wheelchair safety, stress, burn-out, coping, gait belt use, oral care, cell phone use; and, abuse inservice signatures which indicated ninety- four (94) staff members attended the in-service between 04/11/14 and 04/14/14.</p> <p>Review on 05/12/14 of the in-service logs, dated 05/05/14, revealed all staff was inserviced related to abuse, neglect, recognizing and reporting signs of stress and burn-out, and following the plan of care.</p> <p>On 05/12/14 at 2:10 PM, CNA #9 verified through interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p> <p>Interview on 05/12/14 at 2:17 PM with CNA #10; and at 2:40 PM with LPN #4, revealed they had received the in-service education on 05/02/14 by the ADON and they were aware of the signs/symptoms of abuse. The training also included to report to a supervisor immediately any allegation or witnessed abusive situations and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer.</p> <p>On 05/12/14 at 2:45 PM, a housekeeper verified through interview that she had received the inservice education on 05/03/14 by the ADON and she knew to report anything she felt as abusive in nature to a supervisor immediately.</p> <p>On 05/12/14 at 4:55 PM, RN #1; on 05/22/14 at 5:29 PM with RN #2, and at 5:50 PM with CMT #2 verified through interview that they had received</p>	F 282		

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F 282	Continued From page 64 the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings. The inservice also included caregiver stress and signs of burn-out, and if supervisory staff was involved to call on one of the Nuns even to the point of interrupting prayer. Interview on 05/22/14 at 5:55 PM with CNA #11 revealed she had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to call on one of the Nuns even to the point of interrupting prayer. She stated, "I would get a Sister because I feel like we should treat these people like they are our grandparents and you want your grandparents treated well." On 05/22/14 at 5:45 PM, CNA #12 verified through interview that she had received the inservice training by the ADON. The inservice training included forms of abuse; verbal, physical, mental, and misappropriation of resident belongings, the inservice also included caregiver stress and signs of burn-out, and if supervisory staff is involved to call on one of the nuns even to the point of interrupting prayer."If it's wrong it's wrong, you can't let somebody get away with treating somebody mean you got to tell someone." Record review on 05/22/14 at 6:00 PM revealed the abuse allegations, the investigations, and the action plan was reviewed. Further review of a form entitled Continuous Quality Improvement; the Indicator: Knowledge and Compliance of	F 282		

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F 282	<p>Continued From page 65</p> <p>Abuse and Reporting Policy; Recognizing Stress and Burn-out revealed one-hundred-seven (107) [all the facility staff] staff members received the re-education and in-service training and signed the rosters, their time-cards were held until their signatures were obtained in statement of participation. Through explanation by the ADON, random employees were asked Criteria/Question such as: stating the chain of command, know when to report, Identifies signs/symptoms of self stress and self burnout, names of coping strategies, know where to find contact numbers for reporting abuse. Each department will conduct these compliance rounds weekly and calculate the percentage of compliance. This will be conducted under the supervision of the DON and results will be reported to the QA committee. If an acceptable threshold of compliance is not achieved the DON will develop and oversee a corrective action. Compliance rounds are conducted weekly by the Administrative nursing staff to determine that resident care interventions are being provided in accordance with the care plan.</p> <p>Interview on 05/22/14 at 6:15 PM with the Medical Director revealed he was informed of the timing for the QA Committee meetings and he had attended the primary discussion with the Administrator, DON and ADON on 05/06/14. Further interview revealed he felt the facility was taking responsibility and being proactive with the QA plan they have put in place.</p>	F 282		