STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**
NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0157

Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, and review of the facility's policy/procedures it was determined the facility failed to notify the attending physician of a change in condition for one of twenty-nine sampled residents (Resident #18). Resident #18 had an abnormal Urinalysis (UA) on 03/22/13. The facility faxed a copy of the UA results to the physician on 03/22/13 at 4:00 PM; however, there was no evidence the facility followed up with the physician regarding the abnormal UA results. On 03/25/13 (a timeframe of three days after the facility faxed the results of the UA to the physician) a Nurse Practitioner reviewed the results of the UA while at the facility and prescribed an antibiotic for Resident #18 based on the UA results. The findings include: A review of the facility's Change in Condition Action/Notification policy/procedure (dated December 2010) revealed the following: 3. If the change in condition does not appear to be life threatening, utilize a change in condition evaluation tool. 4. Review all findings with the Physician and non-physician practitioner. Fax change in condition form, if applicable. Contact the Physician's office to assure someone is available to receive the fax. If a message is left with the Physician's office personnel and a timely response is not given, follow-up with another message as needed. 5. Document in the medical record all Physician contacts and notifications. Review of the medical record revealed the facility admitted Resident #18 on 06/14/11 with [DIAGNOSES REDACTED]. A review of a physician's telephone order dated 03/21/13 revealed the physician ordered a Urinalysis (UA) for Resident #18 due to dark malodorous urine. The facility received the results of the UA, which were abnormal, on 03/22/13, and faxed the results to the physician at 4:00 PM on 03/22/13. However, there was no evidence in the medical record that the facility followed up on the fax to ensure someone was available to receive the fax of the UA results, followed up with another message as needed, or documented in the medical record all physician contacts and notifications regarding the resident's change in condition. An interview was conducted with Registered Nurse #5 at 5:15 PM on 04/02/13. The RN stated she faxed the UA to the physician on 03/22/13. The RN further stated she did not follow up on the fax and she was off duty the next day. The RN stated staff should have followed up with the physician the following day regarding the abnormal UA. An interview was conducted with the Assistant Director of Nursing (ADON) at 9:20 AM on 04/03/13. According to the ADON, a Nurse Practitioner assessed Resident #18 at the facility during a routine visit on 03/25/13 and determined Resident #18 needed antibiotic therapy due to the abnormal results of the UA. Interview and record review revealed the Nurse Practitioner ordered 50 milligrams (mg) of Nitrofuran (antibiotic) to be administered four times a day, for seven days, for Resident #18 for treatment of [REDACTED].

F 0157

Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, and review of the facility's policy/procedures it was determined the facility failed to notify the attending physician of a change in condition for one of twenty-nine sampled residents (Resident #18). Resident #18 had an abnormal Urinalysis (UA) on 03/22/13. The facility faxed a copy of the UA results to the physician on 03/22/13 at 4:00 PM; however, there was no evidence the facility followed up with the physician regarding the abnormal UA results. On 03/25/13 (a timeframe of three days after the facility faxed the results of the UA to the physician) a Nurse Practitioner reviewed the results of the UA while at the facility and prescribed an antibiotic for Resident #18 based on the UA results. The findings include: A review of the facility's Change in Condition Action/Notification policy/procedure (dated December 2010) revealed the following: 3. If the change in condition does not appear to be life threatening, utilize a change in condition evaluation tool. 4. Review all findings with the Physician and non-physician practitioner. Fax change in condition form, if applicable. Contact the Physician's office to assure someone is available to receive the fax. If a message is left with the Physician's office personnel and a timely response is not given, follow-up with another message as needed. 5. Document in the medical record all Physician contacts and notifications. Review of the medical record revealed the facility admitted Resident #18 on 06/14/11 with [DIAGNOSES REDACTED]. A review of a physician's telephone order dated 03/21/13 revealed the physician ordered a Urinalysis (UA) for Resident #18 due to dark malodorous urine. The facility received the results of the UA, which were abnormal, on 03/22/13, and faxed the results to the physician at 4:00 PM on 03/22/13. However, there was no evidence in the medical record that the facility followed up on the fax to ensure someone was available to receive the fax of the UA results, followed up with another message as needed, or documented in the medical record all physician contacts and notifications regarding the resident's change in condition. An interview was conducted with Registered Nurse #5 at 5:15 PM on 04/02/13. The RN stated she faxed the UA to the physician on 03/22/13. The RN further stated she did not follow up on the fax and she was off duty the next day. The RN stated staff should have followed up with the physician the following day regarding the abnormal UA. An interview was conducted with the Assistant Director of Nursing (ADON) at 9:20 AM on 04/03/13. According to the ADON, a Nurse Practitioner assessed Resident #18 at the facility during a routine visit on 03/25/13 and determined Resident #18 needed antibiotic therapy due to the abnormal results of the UA. Interview and record review revealed the Nurse Practitioner ordered 50 milligrams (mg) of Nitrofuran (antibiotic) to be administered four times a day, for seven days, for Resident #18 for treatment of [REDACTED].

F 0223

Protect each resident from all abuse, physical punishment, and being separated from others.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, and review of the facility's investigation and policies it was determined the facility failed to have an effective system in place to ensure one of twenty-nine sampled residents (Resident #1) was free from abuse. On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker and left a voice mail message on the Social Worker's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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

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F 0223	(continued... from page 1) be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing, and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. A review of the facility's policy revealed the Administrator and/or Director of Nursing (DON) and/or Social Worker was required to make immediate decisions related to the removal of the alleged abuser from direct care/contact. As a result of the facility's investigation, the facility determined the allegation of abuse was unsubstantiated on 02/22/13. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. The facility's failure to have an effective system in place to ensure residents were free from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility including Resident #1. Immediate Jeopardy was identified on 03/01/13 and was determined to exist on 02/17/13, and is ongoing. The facility was notified of the Immediate Jeopardy on 03/01/13. Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices. The findings include: A review of the facility's abuse policy, dated 01/2012, revealed the facility upholds resident rights and strictly prohibits verbal, sexual, physical, and mental abuse of residents. The policy stated that any report or suspicion of an incident of abuse was required to be reported immediately to the charge nurse and/or Abuse Coordinator, as appropriate. The resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. A review of Resident #1's medical record revealed the resident was assessed by the facility to be moderately cognitively impaired, therefore, non-interviewable. Further review revealed the facility had assessed the resident to have a history of pain. A review of a facility pain assessment performed on Resident #1, dated 02/04/13, revealed the resident had episodes of repetitive verbalizations unsure if episodes are pain or not as (he/she) has some actions were pain meds given. A review of Resident #1's physician's orders [REDACTED]. A review of the facility nurse's notes dated 02/14/13, revealed facility staff had contacted the resident's physician related to the resident's increase in pain and requested new pain medication. A review of Resident #1's Plan of Care dated 02/14/13 revealed the physician adjusted Resident #1's pain medications due to the resident's continued repetitive verbalizations and moaning even after the pain medication had been given. A review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying and requesting to go to bed. The investigation revealed staff was interviewed and reported LPN #1 (the charge nurse) would not allow staff to put the resident to bed as the resident was crying and yelling. One staff member reported LPN #1 made a comment that indicated she was going to teach the resident a lesson. Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. In addition, according to the report, LPN #1 stated in interview she wanted Resident #1 to stay at the nurses' station in order for the nurse to monitor the resident's behavior. Documentation in the report revealed other residents on the unit were interviewed and one resident stated he/she had overheard LPN #1 say negative things about another resident. The investigation further stated abuse could not be substantiated. LPN #1 was no longer employed by the facility at the time of the investigation. Attempts to contact LPN #1 for interview were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from the facility on 02/25/13 for falsification of documentation. Review of the facility's witness statement signed by State Registered Nurse Aide (SRNA) #2, and dated 02/17/13, revealed on 02/17/13 after breakfast LPN #1 told staff to leave Resident #1 at the nurses' station. The statement further revealed LPN #1 stated, I'm going to teach (him/her) a lesson for hollering in the dining room. I'm leaving (him/her) up for a while. SRNA #2 reported music was playing at the nurses' station at the time. At approximately 10:00 AM, LPN #1 informed staff they could lay Resident #1 down in bed. An attempt was made on 03/01/13 at 9:55 AM, 03/02/12 at 10:05 AM, and 03/03/13 at 5:05 PM to interview SRNA #2 with no success. An interview with SRNA #3 on 03/01/13 at 12:29 PM, revealed on the morning of 02/17/13, between 9:00 AM and 9:30 AM, Resident #1 was hollering and the SRNA attempted to talk with the resident. According to interview, the resident told SRNA #3 that he/she was hurting and wanted to go to bed. While he was talking to the resident and the resident was hollering, SRNA #3 stated LPN #1 turned up the volume louder on a radio that was playing music at the nurses' station. SRNA #3 stated he wheeled Resident #1 in the wheelchair around the corridors of the building for approximately 10 to 15 minutes and then brought the resident back to the nurses' station and told the staff the resident was hurting and had requested to go to bed. An interview with Kentucky Medication Aide (KMA) #1 on 03/01/13 at 12:01 PM revealed on the morning of 02/17/13 she had administered a physician ordered, scheduled, [MEDICATION NAME] (narcotic pain [MEDICATION NAME]) to Resident #1 at approximately 8:30 AM due to the resident's complaints of pain. A review of Resident #1's Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. According to KMA #1, Resident #1 had told LPN #1 that he/she was in pain. KMA #1 stated she returned to the nurses' station approximately 30 to 45 minutes after she administered the pain medication to Resident #1 to begin a medication pass and the resident was still sitting in the chair at the nurses' station. KMA #1 stated she heard LPN #1 tell the resident in a loud voice, You can't lay down till you stop crying. KMA #1 stated she thought the LPN's remark was inappropriate and was going to report the LPN after she had completed the medication pass; however, when she returned to the nurses' station after passing medications, Resident #1 was no longer sitting at the nurses' station and was lying in bed. KMA #1 stated Resident #1 could tell staff when he/she was hurting and in pain but could not tell staff where the pain was located. KMA #1 stated Resident #1 often experienced increased pain when sitting up in a chair and staff usually assisted the resident to bed after breakfast due to the resident's complaints of increased pain. The interview further revealed KMA #1 thought LPN #1's actions toward Resident #1 were abusive. A review of KMA 1's witness statement, signed and dated 02/17/13 by KMA #1, revealed on 02/17/13 she witnessed LPN #1 tell Resident #1 that the resident would sit up until (he/she) stopped crying, and then the LPN turned up the volume of the radio at the nurses' station. Interview with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM revealed Resident #1 would usually cry after breakfast in the mornings, would request to go to bed, and staff would assist the resident to bed. The housekeeper stated that following breakfast on the morning of 02/17/13 at approximately 7:35 AM, LPN #1 made a comment that Resident #1 was not going to bed because the resident was whining and crying. According to Housekeeper #1, Resident #1 repeatedly said, I want to go to bed, I'm hurting, take me to bed. Housekeeper #1 stated LPN #1 had a tendency to be loud and used a tone that was a combination of hateful and rude. According to Housekeeper #1, on the morning of 02/17/13, LPN #1 was more than just loud and was verbally abusive to Resident #1. Housekeeper #1 further stated LPN #1 wheeled Resident #1 to the nurses' station, placed a radio near Resident #1's head, and turned up the volume of the radio. Review of Housekeeper's #1's written statement signed and dated 02/17/13 revealed after breakfast on the morning of 02/17/13 Resident #1 was crying and wanting to go to bed. LPN #1 told Resident #1 that as long as (he/she) whined and cried, the resident was not going to bed. Further review of the witness statement revealed staff attempted to take the resident to bed and LPN #1 told staff no. The witness statement went on to say LPN #1 obtained a radio, placed it at the nurses' station, and turned it up to drown out Resident #1 crying. Interview with Housekeeper #2 on 03/01/13 at 11:47 AM revealed on the morning of 02/17/13 LPN #1 would not allow facility staff to assist Resident #1 to bed. According to Housekeeper #2, Resident #1 did cry and holler that he/she was in pain and wanted to go to bed. However, according to the housekeeper, LPN #1 stated to the resident that he/she had to sit in front of the desk until the resident quit hollering. Housekeeper #2 further stated LPN #1 obtained a radio, placed it at the nurses' station near the resident's head, and turned the volume up real loud. Further interview revealed she and other staff who had witnessed the incident discussed the incident and felt the incident needed to be reported. Housekeeper #2 stated she and another housekeeper attempted to contact the Social Worker/Abuse Coordinator to report the allegation, but the Social Worker/Abuse Coordinator did not answer the phone and she left a voice message regarding the incident. In addition, a review of the facility's witness statement signed by Housekeeper #2 and dated 02/17/13 revealed LPN #1 was talking to Resident #1 in a way she shouldn't haven't. The witness statement further stated Resident #1 was crying in the dining room at breakfast, and LPN #1 refused to let staff put the resident to bed. According to Housekeeper #2's written statement, LPN #1 wheeled Resident #1 to the nurses' station, obtained a radio, and set it up at the nurses' station and turned it up really loud because the resident was crying. Interview with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and as she was coming out of her office between 11:30 AM and 11:40 AM, Housekeepers #1 and #2 met her in the hall to inform her they felt uneasy about an incident they had witnessed. According to the Staff Development Coordinator/Nurse Manager, the staff stated they were uncomfortable with the tone LPN #1 used with Resident #1. The Staff

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F 0223	(continued... from page 2) Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements. During this time, she stated she attempted to contact the Social Worker/Abuse Coordinator and had to leave a voice message for her and was not able to contact the DON for direction on the allegation. According to the Staff Development Coordinator/Nurse Manager, on 02/17/13 she contacted the facility's Nurse Consultant for direction, and was advised to obtain a written statement from LPN #1 and then to inform the LPN she was being sent home pending the facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, DON, and Nurse Consultant. According to the Staff Development Coordinator/Nurse Manager, LPN #1 was removed from direct care at approximately 12:30 PM after she contacted the Nurse Consultant. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed on 02/17/13, at approximately 12:00 PM, she discovered she had received a voice mail message from the housekeepers at the facility and a second voice mail message from the Staff Development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated she went to the facility on [DATE] and attempted to interview Resident #1; however, she was unable to get an adequate interview due to the resident's cognition level. The Social Worker/Abuse Coordinator stated her part of the investigation was to interview residents related to abuse. While interviewing residents on that day, the Social Worker/Abuse Coordinator stated one resident did report he/she had heard LPN #1 being rude to another resident; however, the resident was unsure if LPN #1 was talking to the resident or about the resident at the time. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed during the investigation he reviewed the witness statements and information that had been obtained, consulted with his regional staff, conducted three or four interviews for follow-up, and re-interviewed LPN #1 to ensure accuracy. According to Administrator #1, LPN #1 admitted Resident #1 was crying and yelling at the nurses' station and the LPN did ask staff to leave the resident up in the chair. According to Administrator #1, LPN #1 told him she wanted to observe the resident to see if the resident was in pain. Administrator #1 acknowledged during interviews he conducted, one SRNA reported LPN #1 stated that she was going to teach a lesson and make the resident stay out there at the nurses' station. Administrator #1 stated after the investigation, interview, and review of the witness statements he felt like he could not come to a firm conclusion to substantiate abuse. He further stated the facility unsubstantiated abuse because staff may have misinterpreted LPN #1's actions.
F 0223	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policies it was determined the facility failed to have an effective system in place to ensure one of twenty-nine sampled residents (Resident #1) was free from abuse. On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker and left a voice mail message on the Social Worker's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing, and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. A review of the facility's policy revealed the Administrator and/or Director of Nursing (DON) and/or Social Worker was required to make immediate decisions related to the removal of the alleged abuser from direct care/contact. As a result of the facility's investigation, the facility determined the allegation of abuse was unsubstantiated on 02/22/13. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. The facility's failure to have an effective system in place to ensure residents were free from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility including Resident #1. Immediate Jeopardy was identified on 03/01/13 and was determined to exist on 02/17/13, and is ongoing. The facility was notified of the Immediate Jeopardy on 03/01/13. Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices. The findings include: A review of the facility's abuse policy, dated 01/2012, revealed the facility upholds resident rights and strictly prohibits verbal, sexual, physical, and mental abuse of residents. The policy stated that any report or suspicion of an incident of abuse was required to be reported immediately to the charge nurse and/or Abuse Coordinator, as appropriate. The resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. A review of Resident #1's medical record revealed the resident was assessed by the facility to be moderately cognitively impaired, therefore, non-interviewable. Further review revealed the facility had assessed the resident to have a history of pain. A review of a facility pain assessment performed on Resident #1, dated 02/04/13, revealed the resident had episodes of repetitive verbalizations unsure if episodes are pain or not as (he/she) has some actions were pain meds given. A review of Resident #1's physician's orders [REDACTED]. A review of the facility nurse's notes dated 02/14/13, revealed facility staff had contacted the resident's physician related to the resident's increase in pain and requested new pain medication. A review of Resident #1's Plan of Care dated 02/14/13 revealed the physician adjusted Resident #1's pain medications due to the resident's continued repetitive verbalizations and moaning even after the pain medication had been given. A review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying and requesting to go to bed. The investigation revealed staff was interviewed and reported LPN #1 (the charge nurse) would not allow staff to put the resident to bed as the resident was crying and yelling. One staff member reported LPN #1 made a comment that indicated she was going to teach the resident a lesson. Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. In addition, according to the report, LPN #1 stated in interview she wanted Resident #1 to stay at the nurses' station in order for the nurse to monitor the resident's behavior. Documentation in the report revealed other residents on the unit were interviewed and one resident stated he/she had overheard LPN #1 say negative things about another resident. The investigation further stated abuse could not be substantiated. LPN #1 was no longer employed by the facility at the time of the investigation. Attempts to contact LPN #1 for interview were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from the facility on 02/25/13 for falsification of documentation. Review of the facility's witness statement signed by State Registered Nurse Aide (SRNA) #2, and dated 02/17/13, revealed on 02/17/13 after breakfast LPN #1 told staff to leave Resident #1 at the nurses' station. The statement further revealed LPN #1 stated, I'm going to teach (him/her) a lesson for hollering in the dining room. I'm leaving (him/her) up for a while. SRNA #2 reported music was playing at the nurses' station at the time. At approximately 10:00 AM, LPN #1 informed staff they could lay Resident #1 down in bed. An attempt was made on 03/01/13 at 9:55 AM, 03/02/12 at 10:05 AM, and 03/03/13 at 5:05 PM to interview SRNA #2 with no success. An interview with SRNA #3 on 03/01/13 at 12:29 PM, revealed on the morning of 02/17/13, between 9:00 AM and 9:30 AM, Resident #1 was hollering and the SRNA attempted to talk with the resident. According to interview, the resident told SRNA #3 that he/she was hurting and wanted to go to bed. While he was talking to the resident and the resident was hollering, SRNA #3 stated LPN #1 turned up the volume louder on a radio that was playing music at the nurses' station. SRNA #3 stated he wheeled Resident #1 in the wheelchair around the corridors of the building for approximately 10 to 15 minutes and then brought the resident back to the nurses' station and told the staff the resident was hurting and had requested to go to bed. An interview with Kentucky Medication Aide (KMA) #1 on 03/01/13 at 12:01 PM revealed on the morning of 02/17/13 she had administered a physician ordered, scheduled, [MEDICATION NAME] (narcotic pain [MEDICATION NAME]) to Resident #1 at approximately 8:30 AM due to the resident's complaints of pain. A review of Resident #1's Medication Administration Record [MEDICATION ADMINISTRATION RECORD

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F 0223	(continued... from page 3) DETAILS REDACTED]. According to KMA #1, Resident #1 had told LPN #1 that he/she was in pain. KMA #1 stated she returned to the nurses' station approximately 30 to 45 minutes after she administered the pain medication to Resident #1 to begin a medication pass and the resident was still sitting in the chair at the nurses' station. KMA #1 stated she heard LPN #1 tell the resident in a loud voice, You can't lay down till you stop crying. KMA #1 stated she thought the LPN's remark was inappropriate and was going to report the LPN after she had completed the medication pass; however, when she returned to the nurses' station after passing medications, Resident #1 was no longer sitting at the nurses' station and was lying in bed. KMA #1 stated Resident #1 could tell staff when he/she was hurting and in pain but could not tell staff where the pain was located. KMA #1 stated Resident #1 often experienced increased pain when sitting up in a chair and staff usually assisted the resident to bed after breakfast due to the resident's complaints of increased pain. The interview further revealed KMA #1 thought LPN #1's actions toward Resident #1 were abusive. A review of KMA 1's witness statement, signed and dated 02/17/13 by KMA #1, revealed on 02/17/13 she witnessed LPN #1 tell Resident #1 that the resident would sit up until (he/she) stopped crying, and then the LPN turned up the volume of the radio at the nurses' station. Interview with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM revealed Resident #1 would usually cry after breakfast in the mornings, would request to go to bed, and staff would assist the resident to bed. The housekeeper stated that following breakfast on the morning of 02/17/13 at approximately 7:35 AM, LPN #1 made a comment that Resident #1 was not going to bed because the resident was whining and crying. According to Housekeeper #1, Resident #1 repeatedly said, I want to go to bed, I'm hurting, take me to bed. Housekeeper #1 stated LPN #1 had a tendency to be loud and used a tone that was a combination of hateful and rude. According to Housekeeper #1, on the morning of 02/17/13, LPN #1 was more than just loud and was verbally abusive to Resident #1. Housekeeper #1 further stated LPN #1 wheeled Resident #1 to the nurses' station, placed a radio near Resident #1's head, and turned up the volume of the radio. Review of Housekeeper's #1's written statement signed and dated 02/17/13 revealed after breakfast on the morning of 02/17/13 Resident #1 was crying and wanting to go to bed. LPN #1 told Resident #1 that as long as (he/she) whined and cried, the resident was not going to bed. Further review of the witness statement revealed staff attempted to take the resident to bed and LPN #1 told staff no. The witness statement went on to say LPN #1 obtained a radio, placed it at the nurses' station, and turned it up to drown out Resident #1 crying. Interview with Housekeeper #2 on 03/01/13 at 11:47 AM revealed on the morning of 02/17/13 LPN #1 would not allow facility staff to assist Resident #1 to bed. According to Housekeeper #2, Resident #1 did cry and holler that he/she was in pain and wanted to go to bed. However, according to the housekeeper, LPN #1 stated to the resident that he/she had to sit in front of the desk until the resident quit hollering. Housekeeper #2 further stated LPN #1 obtained a radio, placed it at the nurses' station near the resident's head, and turned the volume up real loud. Further interview revealed she and other staff who had witnessed the incident discussed the incident and felt the incident needed to be reported. Housekeeper #2 stated she and another housekeeper attempted to contact the Social Worker/Abuse Coordinator to report the allegation, but the Social Worker/Abuse Coordinator did not answer the phone and she left a voice message regarding the incident. In addition, a review of the facility's witness statement signed by Housekeeper #2 and dated 02/17/13 revealed LPN #1 was talking to Resident #1 in a way she shouldn't haven't. The witness statement further stated Resident #1 was crying in the dining room at breakfast, and LPN #1 refused to let staff put the resident to bed. According to Housekeeper #2's written statement, LPN #1 wheeled Resident #1 to the nurses' station, obtained a radio, and set it up at the nurses' station and turned it up really loud because the resident was crying. Interview with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and as she was coming out of her office between 11:30 AM and 11:40 AM, Housekeepers #1 and #2 met her in the hall to inform her they felt uneasy about an incident they had witnessed. According to the Staff Development Coordinator/Nurse Manager, the staff stated they were uncomfortable with the tone LPN #1 used with Resident #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements. During this time, she stated she attempted to contact the Social Worker/Abuse Coordinator and had to leave a voice message for her and was not able to contact the DON for direction on the allegation. According to the Staff Development Coordinator/Nurse Manager, on 02/17/13 she contacted the facility's Nurse Consultant for direction, and was advised to obtain a written statement from LPN #1 and then to inform the LPN she was being sent home pending the facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, DON, and Nurse Consultant. According to the Staff Development Coordinator/Nurse Manager, LPN #1 was removed from direct care at approximately 12:30 PM after she contacted the Nurse Consultant. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed on 02/17/13, at approximately 12:00 PM, she discovered she had received a voice mail message from the housekeepers at the facility and a second voice mail message from the Staff Development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated she went to the facility on [DATE] and attempted to interview Resident #1; however, she was unable to get an adequate interview due to the resident's cognition level. The Social Worker/Abuse Coordinator stated her part of the investigation was to interview residents related to abuse. While interviewing residents on that day, the Social Worker/Abuse Coordinator stated one resident did report he/she had heard LPN #1 being rude to another resident; however, the resident was unsure if LPN #1 was talking to the resident or about the resident at the time. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed during the investigation he reviewed the witness statements and information that had been obtained, consulted with his regional staff, conducted three or four interviews for follow-up, and re-interviewed LPN #1 to ensure accuracy. According to Administrator #1, LPN #1 admitted Resident #1 was crying and yelling at the nurses' station and the LPN did ask staff to leave the resident up in the chair. According to Administrator #1, LPN #1 told him she wanted to observe the resident to see if the resident was in pain. Administrator #1 acknowledged during interviews he conducted, one SRNA reported LPN #1 stated that she was going to teach a lesson and make the resident stay out there at the nurses' station. Administrator #1 stated after the investigation, interview, and review of the witness statements he felt like he could not come to a firm conclusion to substantiate abuse. He further stated the facility unsubstantiated abuse because staff may have misinterpreted LPN #1's actions.
F 0223	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policies it was determined the facility failed to have an effective system in place to ensure one of twenty-nine sampled residents (Resident #1) was free from abuse. On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker and left a voice mail message on the Social Worker's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing, and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. A review of the facility's policy revealed the Administrator and/or Director of Nursing (DON) and/or Social Worker was required to make immediate decisions related to the removal of the alleged abuser from direct care/contact. As a result of the facility's investigation, the facility determined the allegation of abuse was unsubstantiated on 02/22/13. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. The facility's failure to have an effective system in place to ensure residents were free from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility including Resident #1. Immediate Jeopardy was identified on 03/01/13 and was determined to exist on 02/17/13, and is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0223	(continued... from page 4) ongoing. The facility was notified of the Immediate Jeopardy on 03/01/13. Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices. The findings include: A review of the facility's abuse policy, dated 01/2012, revealed the facility upholds resident rights and strictly prohibits verbal, sexual, physical, and mental abuse of residents. The policy stated that any report or suspicion of an incident of abuse was required to be reported immediately to the charge nurse and/or Abuse Coordinator, as appropriate. The resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. A review of Resident #1's medical record revealed the resident was assessed by the facility to be moderately cognitively impaired, therefore, non-interviewable. Further review revealed the facility had assessed the resident to have a history of pain. A review of a facility pain assessment performed on Resident #1, dated 02/04/13, revealed the resident had episodes of repetitive verbalizations unsure if episodes are pain or not as (he/she) has some actions were pain meds given. A review of Resident #1's physician's orders [REDACTED]. A review of the facility nurse's notes dated 02/14/13, revealed facility staff had contacted the resident's physician related to the resident's increase in pain and requested new pain medication. A review of Resident #1's Plan of Care dated 02/14/13 revealed the physician adjusted Resident #1's pain medications due to the resident's continued repetitive verbalizations and moaning even after the pain medication had been given. A review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying and requesting to go to bed. The investigation revealed staff was interviewed and reported LPN #1 (the charge nurse) would not allow staff to put the resident to bed as the resident was crying and yelling. One staff member reported LPN #1 made a comment that indicated she was going to teach the resident a lesson. Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. In addition, according to the report, LPN #1 stated in interview she wanted Resident #1 to stay at the nurses' station in order for the nurse to monitor the resident's behavior. Documentation in the report revealed other residents on the unit were interviewed and one resident stated he/she had overheard LPN #1 say negative things about another resident. The investigation further stated abuse could not be substantiated. LPN #1 was no longer employed by the facility at the time of the investigation. Attempts to contact LPN #1 for interview were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from the facility on 02/25/13 for falsification of documentation. Review of the facility's witness statement signed by State Registered Nurse Aide (SRNA) #2, and dated 02/17/13, revealed on 02/17/13 after breakfast LPN #1 told staff to leave Resident #1 at the nurses' station. The statement further revealed LPN #1 stated, I'm going to teach (him/her) a lesson for hollering in the dining room. I'm leaving (him/her) up for a while. SRNA #2 reported music was playing at the nurses' station at the time. At approximately 10:00 AM, LPN #1 informed staff they could lay Resident #1 down in bed. An attempt was made on 03/01/13 at 9:55 AM, 03/02/12 at 10:05 AM, and 03/03/13 at 5:05 PM to interview SRNA #2 with no success. An interview with SRNA #3 on 03/01/13 at 12:29 PM, revealed on the morning of 02/17/13, between 9:00 AM and 9:30 AM, Resident #1 was hollering and the SRNA attempted to talk with the resident. According to interview, the resident told SRNA #3 that he/she was hurting and wanted to go to bed. While he was talking to the resident and the resident was hollering, SRNA #3 stated LPN #1 turned up the volume louder on a radio that was playing music at the nurses' station. SRNA #3 stated he wheeled Resident #1 in the wheelchair around the corridors of the building for approximately 10 to 15 minutes and then brought the resident back to the nurses' station and told the staff the resident was hurting and had requested to go to bed. An interview with Kentucky Medication Aide (KMA) #1 on 03/01/13 at 12:01 PM revealed on the morning of 02/17/13 she had administered a physician ordered, scheduled, [MEDICATION NAME] (narcotic pain [MEDICATION NAME]) to Resident #1 at approximately 8:30 AM due to the resident's complaints of pain. A review of Resident #1's Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. According to KMA #1, Resident #1 had told LPN #1 that he/she was in pain. KMA #1 stated she returned to the nurses' station approximately 30 to 45 minutes after she administered the pain medication to Resident #1 to begin a medication pass and the resident was still sitting in the chair at the nurses' station. KMA #1 stated she heard LPN #1 tell the resident in a loud voice, You can't lay down till you stop crying. KMA #1 stated she thought the LPN's remark was inappropriate and was going to report the LPN after she had completed the medication pass; however, when she returned to the nurses' station after passing medications, Resident #1 was no longer sitting at the nurses' station and was lying in bed. KMA #1 stated Resident #1 could tell staff when he/she was hurting and in pain but could not tell staff where the pain was located. KMA #1 stated Resident #1 often experienced increased pain when sitting up in a chair and staff usually assisted the resident to bed after breakfast due to the resident's complaints of increased pain. The interview further revealed KMA #1 thought LPN #1's actions toward Resident #1 were abusive. A review of KMA 1's witness statement, signed and dated 02/17/13 by KMA #1, revealed on 02/17/13 she witnessed LPN #1 tell Resident #1 that the resident would sit up until (he/she) stopped crying, and then the LPN turned up the volume of the radio at the nurses' station. Interview with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM revealed Resident #1 would usually cry after breakfast in the mornings, would request to go to bed, and staff would assist the resident to bed. The housekeeper stated that following breakfast on the morning of 02/17/13 at approximately 7:35 AM, LPN #1 made a comment that Resident #1 was not going to bed because the resident was whining and crying. According to Housekeeper #1, Resident #1 repeatedly said, I want to go to bed, I'm hurting, take me to bed. Housekeeper #1 stated LPN #1 had a tendency to be loud and used a tone that was a combination of hateful and rude. According to Housekeeper #1, on the morning of 02/17/13, LPN #1 was more than just loud and was verbally abusive to Resident #1. Housekeeper #1 further stated LPN #1 wheeled Resident #1 to the nurses' station, placed a radio near Resident #1's head, and turned up the volume of the radio. Review of Housekeeper's #1's written statement signed and dated 02/17/13 revealed after breakfast on the morning of 02/17/13 Resident #1 was crying and wanting to go to bed. LPN #1 told Resident #1 that as long as (he/she) whined and cried, the resident was not going to bed. Further review of the witness statement revealed staff attempted to take the resident to bed and LPN #1 told staff no. The witness statement went on to say LPN #1 obtained a radio, placed it at the nurses' station, and turned it up to drown out Resident #1 crying. Interview with Housekeeper #2 on 03/01/13 at 11:47 AM revealed on the morning of 02/17/13 LPN #1 would not allow facility staff to assist Resident #1 to bed. According to Housekeeper #2, Resident #1 did cry and holler that he/she was in pain and wanted to go to bed. However, according to the housekeeper, LPN #1 stated to the resident that he/she had to sit in front of the desk until the resident quit hollering. Housekeeper #2 further stated LPN #1 obtained a radio, placed it at the nurses' station near the resident's head, and turned the volume up real loud. Further interview revealed she and other staff who had witnessed the incident discussed the incident and felt the incident needed to be reported. Housekeeper #2 stated she and another housekeeper attempted to contact the Social Worker/Abuse Coordinator to report the allegation, but the Social Worker/Abuse Coordinator did not answer the phone and she left a voice message regarding the incident. In addition, a review of the facility's witness statement signed by Housekeeper #2 and dated 02/17/13 revealed LPN #1 was talking to Resident #1 in a way she shouldn't haven't. The witness statement further stated Resident #1 was crying in the dining room at breakfast, and LPN #1 refused to let staff put the resident to bed. According to Housekeeper #2's written statement, LPN #1 wheeled Resident #1 to the nurses' station, obtained a radio, and set it up at the nurses' station and turned it up really loud because the resident was crying. Interview with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and as she was coming out of her office between 11:30 AM and 11:40 AM, Housekeepers #1 and #2 met her in the hall to inform her they felt uneasy about an incident they had witnessed. According to the Staff Development Coordinator/Nurse Manager, the staff stated they were uncomfortable with the tone LPN #1 used with Resident #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements. During this time, she stated she attempted to contact the Social Worker/Abuse Coordinator and had to leave a voice message for her and was not able to contact the DON for direction on the allegation. According to the Staff Development Coordinator/Nurse Manager, on 02/17/13 she contacted the facility's Nurse Consultant for direction, and was advised to obtain a written statement from LPN #1 and then to inform the LPN she was being sent home pending the facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, DON, and Nurse Consultant. According to the Staff Development Coordinator/Nurse Manager, LPN #1 was removed from direct care at approximately 12:30 PM after she contacted the Nurse Consultant. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed on 02/17/13, at approximately 12:00 PM, she discovered she had received a voice mail message from the housekeepers at the facility and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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F 0223	(continued... from page 5) second voice mail message from the Staff Development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated she went to the facility on [DATE] and attempted to interview Resident #1; however, she was unable to get an adequate interview due to the resident's cognition level. The Social Worker/Abuse Coordinator stated her part of the investigation was to interview residents related to abuse. While interviewing residents on that day, the Social Worker/Abuse Coordinator stated one resident did report he/she had heard LPN #1 being rude to another resident; however, the resident was unsure if LPN #1 was talking to the resident or about the resident at the time. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed during the investigation he reviewed the witness statements and information that had been obtained, consulted with his regional staff, conducted three or four interviews for follow-up, and re-interviewed LPN #1 to ensure accuracy. According to Administrator #1, LPN #1 admitted Resident #1 was crying and yelling at the nurses' station and the LPN did ask staff to leave the resident up in the chair. According to Administrator #1, LPN #1 told him she wanted to observe the resident to see if the resident was in pain. Administrator #1 acknowledged during interviews he conducted, one SRNA reported LPN #1 stated that she was going to teach a lesson and make the resident stay out there at the nurses' station. Administrator #1 stated after the investigation, interview, and review of the witness statements he felt like he could not come to a firm conclusion to substantiate abuse. He further stated the facility unsubstantiated abuse because staff may have misinterpreted LPN #1's actions.
F 0223	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policies it was determined the facility failed to have an effective system in place to ensure one of twenty-nine sampled residents (Resident #1) was free from abuse. On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker and left a voice mail message on the Social Worker's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing, and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. A review of the facility's policy revealed the Administrator and/or Director of Nursing (DON) and/or Social Worker was required to make immediate decisions related to the removal of the alleged abuser from direct care/contact. As a result of the facility's investigation, the facility determined the allegation of abuse was unsubstantiated on 02/22/13. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. The facility's failure to have an effective system in place to ensure residents were free from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility including Resident #1. Immediate Jeopardy was identified on 03/01/13 and was determined to exist on 02/17/13, and is ongoing. The facility was notified of the Immediate Jeopardy on 03/01/13. Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices. The findings include: A review of the facility's abuse policy, dated 01/2012, revealed the facility upholds resident rights and strictly prohibits verbal, sexual, physical, and mental abuse of residents. The policy stated that any report or suspicion of an incident of abuse was required to be reported immediately to the charge nurse and/or Abuse Coordinator, as appropriate. The resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. A review of Resident #1's medical record revealed the resident was assessed by the facility to be moderately cognitively impaired, therefore, non-interviewable. Further review revealed the facility had assessed the resident to have a history of pain. A review of a facility pain assessment performed on Resident #1, dated 02/04/13, revealed the resident had episodes of repetitive verbalizations unsure if episodes are pain or not as (he/she) has some actions were pain meds given. A review of Resident #1's physician's orders [REDACTED]. A review of the facility nurse's notes dated 02/14/13, revealed facility staff had contacted the resident's physician related to the resident's increase in pain and requested new pain medication. A review of Resident #1's Plan of Care dated 02/14/13 revealed the physician adjusted Resident #1's pain medications due to the resident's continued repetitive verbalizations and moaning even after the pain medication had been given. A review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying and requesting to go to bed. The investigation revealed staff was interviewed and reported LPN #1 (the charge nurse) would not allow staff to put the resident to bed as the resident was crying and yelling. One staff member reported LPN #1 made a comment that indicated she was going to teach the resident a lesson. Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. In addition, according to the report, LPN #1 stated in interview she wanted Resident #1 to stay at the nurses' station in order for the nurse to monitor the resident's behavior. Documentation in the report revealed other residents on the unit were interviewed and one resident stated he/she had overheard LPN #1 say negative things about another resident. The investigation further stated abuse could not be substantiated. LPN #1 was no longer employed by the facility at the time of the investigation. Attempts to contact LPN #1 for interview were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from the facility on 02/25/13 for falsification of documentation. Review of the facility's witness statement signed by State Registered Nurse Aide (SRNA) #2, and dated 02/17/13, revealed on 02/17/13 after breakfast LPN #1 told staff to leave Resident #1 at the nurses' station. The statement further revealed LPN #1 stated, I'm going to teach (him/her) a lesson for hollering in the dining room. I'm leaving (him/her) up for a while. SRNA #2 reported music was playing at the nurses' station at the time. At approximately 10:00 AM, LPN #1 informed staff they could lay Resident #1 down in bed. An attempt was made on 03/01/13 at 9:55 AM, 03/02/12 at 10:05 AM, and 03/03/13 at 5:05 PM to interview SRNA #2 with no success. An interview with SRNA #3 on 03/01/13 at 12:29 PM, revealed on the morning of 02/17/13, between 9:00 AM and 9:30 AM, Resident #1 was hollering and the SRNA attempted to talk with the resident. According to interview, the resident told SRNA #3 that he/she was hurting and wanted to go to bed. While he was talking to the resident and the resident was hollering, SRNA #3 stated LPN #1 turned up the volume louder on a radio that was playing music at the nurses' station. SRNA #3 stated he wheeled Resident #1 in the wheelchair around the corridors of the building for approximately 10 to 15 minutes and then brought the resident back to the nurses' station and told the staff the resident was hurting and had requested to go to bed. An interview with Kentucky Medication Aide (KMA) #1 on 03/01/13 at 12:01 PM revealed on the morning of 02/17/13 she had administered a physician ordered, scheduled, [MEDICATION NAME] (narcotic pain [MEDICATION NAME]) to Resident #1 at approximately 8:30 AM due to the resident's complaints of pain. A review of Resident #1's Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. According to KMA #1, Resident #1 had told LPN #1 that he/she was in pain. KMA #1 stated she returned to the nurses' station approximately 30 to 45 minutes after she administered the pain medication to Resident #1 to begin a medication pass and the resident was still sitting in the chair at the nurses' station. KMA #1 stated she heard LPN #1 tell the resident in a loud voice, You can't lay down till you stop crying. KMA #1 stated she thought the LPN's remark was inappropriate and was going to report the LPN after she had completed the medication pass; however, when she returned to the nurses' station after passing medications, Resident #1 was no longer sitting at the nurses' station and was lying in bed. KMA #1 stated Resident #1 could tell staff when he/she was hurting and in pain but could not tell staff where the pain was located. KMA #1 stated Resident #1 often experienced increased pain when sitting up in a chair and staff usually assisted the resident to bed after breakfast due to the resident's complaints of increased pain. The interview further revealed KMA #1 thought LPN #1's actions toward Resident #1 were abusive. A review of KMA 1's witness statement, signed and dated 02/17/13 by KMA #1, revealed on 02/17/13 she witnessed LPN #1 tell Resident #1 that the resident would sit up until

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NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0223	(continued... from page 6) (he/she) stopped crying, and then the LPN turned up the volume of the radio at the nurses' station. Interview with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM revealed Resident #1 would usually cry after breakfast in the mornings, would request to go to bed, and staff would assist the resident to bed. The housekeeper stated that following breakfast on the morning of 02/17/13 at approximately 7:35 AM, LPN #1 made a comment that Resident #1 was not going to bed because the resident was whining and crying. According to Housekeeper #1, Resident #1 repeatedly said, I want to go to bed, I'm hurting, take me to bed. Housekeeper #1 stated LPN #1 had a tendency to be loud and used a tone that was a combination of hateful and rude. According to Housekeeper #1, on the morning of 02/17/13, LPN #1 was more than just loud and was verbally abusive to Resident #1. Housekeeper #1 further stated LPN #1 wheeled Resident #1 to the nurses' station, placed a radio near Resident #1's head, and turned up the volume of the radio. Review of Housekeeper's #1's written statement signed and dated 02/17/13 revealed after breakfast on the morning of 02/17/13 Resident #1 was crying and wanting to go to bed. LPN #1 told Resident #1 that as long as (he/she) whined and cried, the resident was not going to bed. Further review of the witness statement revealed staff attempted to take the resident to bed and LPN #1 told staff no. The witness statement went on to say LPN #1 obtained a radio, placed it at the nurses' station, and turned it up to drown out Resident #1 crying. Interview with Housekeeper #2 on 03/01/13 at 11:47 AM revealed on the morning of 02/17/13 LPN #1 would not allow facility staff to assist Resident #1 to bed. According to Housekeeper #2, Resident #1 did cry and holler that he/she was in pain and wanted to go to bed. However, according to the housekeeper, LPN #1 stated to the resident that he/she had to sit in front of the desk until the resident quit hollering. Housekeeper #2 further stated LPN #1 obtained a radio, placed it at the nurses' station near the resident's head, and turned the volume up real loud. Further interview revealed she and other staff who had witnessed the incident discussed the incident and felt the incident needed to be reported. Housekeeper #2 stated she and another housekeeper attempted to contact the Social Worker/Abuse Coordinator to report the allegation, but the Social Worker/Abuse Coordinator did not answer the phone and she left a voice message regarding the incident. In addition, a review of the facility's witness statement signed by Housekeeper #2 and dated 02/17/13 revealed LPN #1 was talking to Resident #1 in a way she shouldn't haven't. The witness statement further stated Resident #1 was crying in the dining room at breakfast, and LPN #1 refused to let staff put the resident to bed. According to Housekeeper #2's written statement, LPN #1 wheeled Resident #1 to the nurses' station, obtained a radio, and set it up at the nurses' station and turned it up really loud because the resident was crying. Interview with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and as she was coming out of her office between 11:30 AM and 11:40 AM, Housekeepers #1 and #2 met her in the hall to inform her they felt uneasy about an incident they had witnessed. According to the Staff Development Coordinator/Nurse Manager, the staff stated they were uncomfortable with the tone LPN #1 used with Resident #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements. During this time, she stated she attempted to contact the Social Worker/Abuse Coordinator and had to leave a voice message for her and was not able to contact the DON for direction on the allegation. According to the Staff Development Coordinator/Nurse Manager, on 02/17/13 she contacted the facility's Nurse Consultant for direction, and was advised to obtain a written statement from LPN #1 and then to inform the LPN she was being sent home pending the facility investigation. Further interview revealed LPN #1 continued to remain in the facility at the nurses' station during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, DON, and Nurse Consultant. According to the Staff Development Coordinator/Nurse Manager, LPN #1 was removed from direct care at approximately 12:30 PM after she contacted the Nurse Consultant. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed on 02/17/13, at approximately 12:00 PM, she discovered she had received a voice mail message from the housekeepers at the facility and a second voice mail message from the Staff Development Coordinator/Nurse Manager. After she received the calls, the Social Worker/Abuse Coordinator stated she went to the facility on [DATE] and attempted to interview Resident #1; however, she was unable to get an adequate interview due to the resident's cognition level. The Social Worker/Abuse Coordinator stated her part of the investigation was to interview residents related to abuse. While interviewing residents on that day, the Social Worker/Abuse Coordinator stated one resident did report he/she had heard LPN #1 being rude to another resident; however, the resident was unsure if LPN #1 was talking to the resident or about the resident at the time. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed during the investigation he reviewed the witness statements and information that had been obtained, consulted with his regional staff, conducted three or four interviews for follow-up, and re-interviewed LPN #1 to ensure accuracy. According to Administrator #1, LPN #1 admitted Resident #1 was crying and yelling at the nurses' station and the LPN did ask staff to leave the resident up in the chair. According to Administrator #1, LPN #1 told him she wanted to observe the resident to see if the resident was in pain. Administrator #1 acknowledged during interviews he conducted, one SRNA reported LPN #1 stated that she was going to teach a lesson and make the resident stay out there at the nurses' station. Administrator #1 stated after the investigation, interview, and review of the witness statements he felt like he could not come to a firm conclusion to substantiate abuse. He further stated the facility unsubstantiated abuse because staff may have misinterpreted LPN #1's actions.
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to have an effective system to ensure all allegations of abuse were reported immediately to the Administrator of the facility, failed to protect residents after an allegation of abuse, and failed to ensure all alleged violations were thoroughly investigated for six of twenty-nine sampled residents (Resident #1, #4, #19, #29, #30, and #31). On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the Nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker/Abuse Coordinator and left a voice mail message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing (DON), and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. According to the facility investigation, dated 02/22/13, after the investigation was completed the facility unsubstantiated that abuse occurred. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223.) In addition, on the morning of 03/24/13, at approximately 12:00 AM, Resident #4 reported to Registered Nurse (RN) #8 that RN #8 was mean to the resident; that the resident did not want RN #8 to provide care for the resident anymore; and, asked RN #8 to not come back into the resident's room. RN #8 documented the incident in Resident #4's medical record and reported the incident to the oncoming Nurse (RN #4) at 7:00 AM. RN #4 reported the incident to the Weekend Manager on 03/24/13, and the Weekend Manager contacted the DON to report the incident. However, the DON did not initiate an investigation of the incident and did not notify the Administrator of the incident. On 03/27/13, the facility's Cooperate Nurse Consultant learned of the incident through review of Resident #4's medical record. The DON and Administrator #2 interviewed RN #8 about the incident prior to the start of her shift on 03/27/13. However, the DON and Administrator #2 allowed RN #8 to continue to provide direct care to residents in the facility during her scheduled twelve (12) hour shift on 03/27/13 and, as a result, failed to ensure residents in the facility were protected from further potential abuse while the facility's investigation was in progress. In addition, the facility failed to ensure four (4) other potential allegations of abuse were thoroughly investigated and

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F 0225

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reported to the appropriate State Agencies; alleged verbal abuse involving Resident #19; Resident #29 expressing fear of State Registered Nurse Aide (SRNA) #14; Resident #30 being sprayed with cold water and having a towel wrapped around his/her neck; and, Resident #31 being handled roughly by staff while being placed in a chair. The facility's failure to immediately report an allegation of abuse, failure to protect residents during the course of an investigation of abuse, and failure to thoroughly investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F225- S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: 1. Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Based on a review of the facility's investigation, dated 02/22/13, and interviews with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM, with Housekeeper #2 on 03/01/13 at 11:47 AM, with SRNA #3 on 03/01/13 at 12:29 PM, with Kentucky Medication Aide (KMA)
#1 on 03/01/13 at 12:01 PM, and review of a witness statement provided by SRNA #2 (unable to be reached for interview), LPN #1 was observed to abuse Resident #1. However, no action was immediately taken by the staff who witnessed the abuse to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, when Housekeeper #1 attempted to notify the Social Worker/Abuse Coordinator, as directed in the facility's policy, via phone, but was unable to reach her, and left a message describing what she had witnessed. Housekeeper #1 and Housekeeper #2 stated they did not immediately report the abuse due to being nervous, scared, and did not know what to do, since the abuse had been committed by the Charge Nurse. Housekeeper #1 stated after leaving the voice message for the Abuse Coordinator, she observed the Staff Development Coordinator in the facility and immediately reported what she had witnessed to her. An interview conducted with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, on 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and was approached by Housekeepers #1 and #2 at approximately 11:40 AM, reporting the incident they witnessed concerning Resident #1 and LPN #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements, but took no action to protect residents in the facility from further abuse by the LPN. The Staff Development Coordinator/Nurse Manager stated she did not have the authority to remove LPN #1 (Charge Nurse) from patient care, stating only the Administrator, Social Worker/Abuse Coordinator, or Director of Nursing had that authority. The Staff Development Coordinator/Nurse Manager stated she also attempted to contact the Social Worker/Abuse Coordinator, time unknown, but was unable to reach her and left a voice message. The Staff Development Coordinator/Nurse Manager stated she was unable to notify the DON of the alleged abuse due to not having access to her current phone number. According to the Staff Development Coordinator/Nurse Manager, LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse was observed) when the Staff Development Coordinator/Nurse Manager contacted the facility's Nurse Consultant via telephone and was instructed to suspend LPN #1, the Charge Nurse. However, review of the facility's policy revealed residents would receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed once she discovered and listened to the voice messages from Housekeeper #1 and the Staff Development Coordinator/Nurse Manager on 02/17/13 (time unknown) she went to the facility to assist with the investigation. According to the Social Worker/Abuse Coordinator staff was required to report any allegations of abuse to the Abuse Coordinator (herself), the Administrator, the DON, or the Charge Nurse. However, the facility had no specific detailed reporting procedure such as an on call system, to ensure staff was able to report abuse as the facility policy directs. The Social Worker/Abuse Coordinator stated there was no written order of whom to report abuse to, and staff would have to go through the individuals listed in the policy until one was reached. The Social Worker/Abuse Coordinator further stated she was allowed to remove alleged perpetrators from resident care and she was unaware if another Nurse had the authority to remove alleged perpetrators from direct care after an allegation of abuse had been alleged. Interview further revealed when an allegation of abuse was made she, the DON, and the Administrator, performed the investigation. According to the Social Worker/Abuse Coordinator depending on who got to the facility first, the others would just see who did what and assist with the investigation. The Social Worker/Abuse Coordinator stated the Administrator was ultimately responsible for the decision to determine if a staff member had committed an abusive act toward a resident, and made decisions regarding all disciplinary action. Review of the facility's policy revealed only the Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Administrator #1 stated in an interview conducted on 02/28/13 at 5:20 PM that his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. According to Administrator #1 when he interviewed LPN #1, she did confirm Resident #1 was crying and yelling at the Nurses' station and she (the Charge Nurse) instructed staff to leave the resident up in the chair, but explained that it was to observe the resident. Administrator #1 also acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson. Additionally, the Abuse Coordinator had reported that although she had been unable to get specifics of the alleged incident from Resident #1 due to (his/her) impaired cognition, an alert and oriented resident had reported witnessing LPN #1 being inappropriate and rude to another resident previously. However, after considering all the information that had been obtained during the investigation, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1, and therefore unsubstantiated the allegation, and took no further disciplinary action against LPN #1 in regard to the alleged abuse to Resident #1. Review of the facility's abuse policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. At the time of the investigation, LPN #1, the Charge Nurse, was no longer employed by the facility, and attempts to interview her were unsuccessful. 2. Review of the medical record revealed the facility admitted Resident #29 on 03/18/10 with [DIAGNOSES REDACTED]. A list of residents assessed by the facility to be alert, oriented and interviewable was provided on 04/02/13. According to the list, the facility had assessed Resident #29 to be alert, oriented, and interviewable. Resident #29 was observed sitting in a wheelchair in the facility dining room on 04/05/13 at 5:50 PM. Interview conducted on 04/05/13, at 5:50 PM with Resident #29 revealed he/she was afraid of a staff person (SRNA #14). The resident stated SRNA #14 had touched his/her breast when the SRNA hugged the resident approximately 2-3 months ago, and would come into the resident's room without knocking when the resident was disrobed. Resident #29 stated he/she reported the incident that occurred 2-3 months ago to the facility's Social Worker/Abuse Coordinator at the time the incident occurred. The resident stated SRNA #14 had been moved to another area in the facility after he/she reported the incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM, revealed Resident #29 reported to her on 03/01/13 that SRNA #14 had touched the resident's breast and, although Resident #29 reportedly did not feel SRNA #14's action was abuse, the resident felt the his actions were inappropriate. According to

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F 0225	(continued... from page 8) the Social Worker/Abuse Coordinator, she had the responsibility to investigate allegations of abuse, to report the allegation to the appropriate state agencies, and to provide administrative staff a report of her findings. The Social Worker/Abuse Coordinator stated on 03/01/13, she and Administrator #1 talked with Resident #29 regarding the reported incident and informed Resident #29 that SRNA #14 would be reassigned to another area in the facility. The Social Worker/Abuse Coordinator stated she obtained verbal statements from Resident #29; Resident #29's daughter; and SRNA #14; and a written statement from a staff Nurse that had been assigned to the Seasons unit at the time the resident reported the incident. The Social Worker/Abuse Coordinator stated as a result of the allegation made by Resident #29, SRNA #14 was reassigned to another unit of the facility and was permitted to continue to provide direct care to residents. In addition, the Social Worker/Abuse Coordinator stated she had not considered the incident to be possible abuse; did not conduct further investigation of the allegation; and did not report the incident to the appropriate state agencies. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the Social Worker/Abuse Coordinator, as part of her responsibilities of abuse investigations, she was responsible to remove the alleged perpetrator from resident care and to provide administrative staff the results of her investigation. Administrator #1 was no longer employed as Administrator of the facility and an interview could not be obtained with Administrator #1. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was also currently acting as the facility's Administrator. The Vice President of Operations stated although he was not aware of the incident involving Resident #29, he would attempt to locate the facility's investigation. Continued interview with the Vice President of Operations on 04/05/13 at 7:30 PM revealed SRNA #14 had continued to work at the facility and was working on 04/05/13 when Resident #29 reported the incident to the surveyor. According to the Vice President of Operations, the facility's investigation of the incident consisted of the interviews that had been obtained by the Social Worker/Abuse Coordinator. The Vice President of Operations stated effective 04/05/13 SRNA #14 had been suspended from employment pending further investigation of the incident. The Vice President of Operations stated he did recall Administrator #1 telling him SRNA #14 had been moved to another area of the facility to work due to a resident telling staff he/she did not want SRNA #14 providing their care. However, the Vice President of Operations stated he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. A review of a facility's investigation revealed on 03/24/13, Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. According to investigation witness statements and an investigation was started on 03/24/13 by the facility's Social Worker/Abuse Coordinator. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident. Additional review on 04/09/13 revealed the facility had not completed the investigation and had failed to report the allegation to the appropriate State Agencies until 04/09/13, sixteen (16) days after the alleged incident was reported. In addition, there was no evidence the alleged perpetrator had been suspended. However, the facility's policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the initial report of the allegation dated 04/09/13, revealed that SRNA #13 was not on duty, the facility had attempted to contact SRNA #13, and SRNA #13 would be suspended and not allowed to work until the investigation had cleared the SRNA of the allegation. A review of the facility's investigation log revealed no entry regarding Resident #30. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed, on 04/08/13, the Social Worker/Abuse Coordinator informed the Administrator of the allegation of abuse that had occurred on 03/22/13 and involved Resident #30. According to the Social Worker/Abuse Coordinator, it was the Social Worker/Abuse Coordinator's responsibility to report the allegation to the Administrator and the Director of Nursing. In addition, the Social Worker/Abuse Coordinator stated, the facility's investigation of the allegation that had reportedly occurred on 03/22/13 had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was aware the Social Worker/Abuse Coordinator was talking with Resident #30 on 03/24/13, however; was not aware of an abuse allegation. According to Administrator #2 he was not aware of the allegation of abuse had not been thoroughly investigated and reported as required until the investigation file was found on 04/08/13. 4. Interview with facility Administrator #2 on 03/28/13 at 1:50 PM revealed there had been an allegation of abuse that he planned to report to the appropriate State Agencies. Administrator #2 stated the incident occurred on 03/24/13, was reported on 03/27/13, and the facility was in the process of conducting an investigation. According to Administrator #2, a resident said a Nurse was mean to her/him, but no abuse occurred. Administrator #2 further stated the DON was aware of the allegation on 03/24/13, the date of the alleged abuse, and confirmed an investigation of the incident had not been initiated on 03/24/13 by the facility. Review of an investigation conducted by the facility dated 04/01/13 revealed on 03/24/13 Resident #4 alleged RN #8 was mean to the resident and the resident did not want the Nurse to provide care for her/him. According to the investigation Resident #8 was interviewed on 03/28/13, and reported no one was mean to her/him. The investigation also revealed the resident reported one of the women was mean to her, and stated it was RN #8; however, documentation in the report revealed the resident stated he/she didn't really mean it. Further review of the investigation revealed RN #8 verified Resident #4 had told her that she was mean to the resident on 03/24/13. Based on the facility's investigation the facility unsubstantiated abuse based on the resident's moderately impaired cognitive ability. Review of Resident #4's medical record revealed on 02/01/13 the facility assessed the resident's cognition level as moderately impaired when a significant change in status Minimum Data Set (MDS) assessment had been completed. Interview with Resident #4 on 03/29/13 at 4:00 PM, revealed the resident did not remember the date but stated a few days ago, he/she needed to go to the restroom during the night and turned the call light on to alert staff. Resident #4 stated he/she could not wait and went to the restroom alone. According to Resident #4, RN #8 came in and started telling the resident not to get up unassisted and to wait for help. Resident #4 stated RN #8 was being loud and the resident did not like it. The resident stated he/she told the RN she was being mean; that the resident did not want the RN to provide care for him/her; and, not to come back into the resident's room. Resident #4 stated that later in the morning, he/she told RN #8 that he/she was sorry and the resident did not think the RN was mean. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on 03/24/13, around midnight, Resident #4 rang the call light and the RN went into the room. The RN found the resident in the restroom and instructed the resident to wait for assistance before getting up. According to the RN, the resident became angry and upset and yelled at the RN don't fuss, don't quarrel. RN #8 further stated she went into Resident #8's room again between 2:00 AM and 4:00 AM when the resident's call light was sounding and the resident told the RN he/she did not want the RN to take care of her/him anymore, and stated they could not get along and the resident did not want the Nurse coming in the resident's room anymore. RN #8 further stated around 6:00 AM on 03/24/13 Resident #4 told her she could provide care for her and the resident did not think the RN was mean. Further interview revealed the RN had informed in a casual way RN #9 on B wing of what the resident stated and SRNA #14 and #15 were also aware of Resident #4 being upset with RN #8. However, according to RN #8 she did not inform the DON or Administrator of the incident. Further interview revealed on 03/27/13 around 6:00 PM the DON called and asked the RN to come in early for work. RN #8 stated when she arrived, the DON asked her about the incident on 03/24/13. RN #8 stated she explained the incident and the DON informed her it should have been reported to the DON and Administrator as an allegation of abuse. RN #8 stated after speaking with the DON on 03/27/13 she went out on the floor and worked her twelve (12) hours scheduled shift. Interview with RN #9 on 03/29/13 at 8:02 PM revealed he did remember RN #8 coming to B wing on the morning of 03/24/13 crying. However, he did not remember anything related to Resident #4. Interview with SRNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, RN #8 informed her about the incident with Resident #4. According to SRNA #14 she did not hear the exchange between RN #8 and the resident. SRNA #14 stated she should have reported the incident to another Nurse but it didn't enter her mind to do that. Interview with SRNA #15 on 03/29/13 at 2:34 PM revealed on the morning of 03/24/13 the SRNA came to work at 5:00 AM and RN #8 informed her about the incident between the RN and Resident #4. SRNA #15 stated she did not report the information to the DON or Administrator as she had been instructed to. Interview with RN #4 on 03/29/13 at 7:35 PM revealed she worked on the morning of 03/24/13. According to RN #4, RN #8 informed her during change of shift of the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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F 0225	(continued... from page 9) between the RN and Resident #8. RN #4 stated RN #8 informed her she had documented the incident in the resident's Nurse's Notes and did not know what else to do about it. RN #4 further stated around 9:00 AM on 03/24/13 she reported the incident to the Weekend Manager because it was charted in the Nurse's Notes; in case there was a need to open an investigation. RN #4 went on to state if it had not been charted she wouldn't have been so concerned about reporting it. Further interview revealed RN #4 did not report the incident to the DON or Administrator because she didn't see any immediate harm. RN #4 stated she didn't feel abuse occurred, since the resident was fine, everything was fine, and since RN #8 did not go back into Resident #4's room. Interview with the Weekend Manager, who was the Dietary Manager, on 03/28/13 at 6:41 PM, revealed she was the Manager on Duty on Sunday 03/24/13. When she came in that morning she went to each Nurse's station to talk with Nurses. According to the Weekend Manager, RN #4 informed her of the incident that transpired between RN #8 and Resident #4 during the early morning. The Weekend Manager stated she called the DON around 10:00 AM on 03/24/13 to inform her of the incident. The Weekend Manager stated the DON told her the way the situation was handled was fine since Resident #4 told RN #8 she did not think the RN was mean. The Weekend Manager stated she did not pursue an investigation after speaking with the DON, nor did she report the incident to the Administrator. Interview with the DON on 04/02/13 at 8:45 PM revealed she was aware of the incident between Resident #4 and RN #8 that had occurred on 03/24/13. She stated the Weekend Manager had informed her of the situation on 03/24/13 and she did not give the Weekend Manager any further instructions. However, the DON did not initiate an investigation nor did she notify the Administrator. The DON stated on 03/27/13, the Corporate Nurse Consultant contacted her regarding the incident after she had read it in the Nurse's Notes. The DON stated, at that time, she called RN #8 and asked her to come to the facility for interview. The DON further stated she and Administrator #2 allowed the RN to continue working on 03/27/13 after interviewing her and prior to the finishing the investigation that was initiated on 03/27/13. The DON stated after she and Administrator #2 interviewed RN #8, they determined abuse had not occurred. Interview with the Cooperate Nurse Consultant on 03/28/13 at 7:45 PM revealed on 03/27/13 she was training another corporate staff member while performing audits of resident medical records. According to the Corporate Nurse Consultant, the trainee was reviewing Resident #4's chart and discovered Nurses' Notes from 03/24/13 regarding the incident between the resident and RN #8. Further interview revealed she called the DON, who was in the building, to question if she was aware of the incident. The DON informed her she was, but had forgotten to investigate it and report it to anyone else. The Cooperate Nurse Consultant stated on 03/27/13 she called the Chief Nurse Executive to inform her of the findings. The Chief Nurse Executive informed her to interview RN #8 and obtain a statement. Interview further revealed, after the interview had been conducted, she did not conduct a follow-up to ensure an investigation had been initiated and residents were protected. The Cooperate Nurse Consultant stated she was not aware RN #8 was permitted to work the shift on the evening of 03/27/13. Interview with the Chief Nurse Executive on 03/29/13 at 3:25 PM revealed she did receive a call on 03/27/13 concerning the incident between RN #8 and Resident #4. She instructed the Cooperate Nurse Consultant to obtain a statement from the RN and that she would notify the Cooperate Regional Controller, who was in charge while the Vice President of Operations was away. Further interview revealed she did notify the Corporate Regional Controller who stated this is not good, and stated she would notify the Administrator. According to the Chief Nurse Executive, even though she thought they needed to suspend the Nurse, she provided no additional input into the investigation. Interview with the Cooperate Regional Controller on 03/29/13 at 2:15 PM revealed she was notified on 03/27/13 by the Chief Nurse Executive of the incident between Resident #4 and RN #8. She further stated she informed the Chief Nurse Executive that she would notify the Administrator. Further interview revealed she was not aware RN #8 was permitted to work on the evening of 03/27/13 because, at that point, the investigation had just been initiated. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM, revealed he became aware of the incident on 03/27/13 at approximately 5:40 PM and went to speak with the DON regarding the incident. According to Administrator #2 the DON informed him she had forgotten to notify him of the allegation and failed to initiate an investigation into the incident. Administrator #2 further stated on 03/27/13 when the DON acknowledged the incident and reported she had forgotten to conduct an investigation; the DON called RN #8 into the office to question her regarding the incident. Administrator #2 stated although he sat in during the interview, he was half paying attention. Administrator #2 further stated he was aware the RN was permitted to work after being interviewed on 03/27/13 while the investigation was in progress. However, review of the facility's abuse policy revealed the resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Further interview with Administrator #2 revealed he did not think it (the allegation) was reportable, he stated in my heart of hearts I have gotten to know the little girl (RN #8) while I've been here, I just didn't feel it was true and reportable. He stated as of 03/29/13 RN #8 was on suspension and the decision to let her work on
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to have an effective system to ensure all allegations of abuse were reported immediately to the Administrator of the facility, failed to protect residents after an allegation of abuse, and failed to ensure all alleged violations were thoroughly investigated for six of twenty-nine sampled residents (Resident #1, #4, #19, #29, #30, and #31). On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the Nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker/Abuse Coordinator and left a voice mail message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing (DON), and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. According to the facility investigation, dated 02/22/13, after the investigation was completed the facility unsubstantiated that abuse occurred. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223.) In addition, on the morning of 03/24/13, at approximately 12:00 AM, Resident #4 reported to Registered Nurse (RN) #8 that RN #8 was mean to the resident; that the resident did not want RN #8 to provide care for the resident anymore; and, asked RN #8 to not come back into the resident's room. RN #8 documented the incident in Resident #4's medical record and reported the incident to the oncoming Nurse (RN #4) at 7:00 AM. RN #4 reported the incident to the Weekend Manager on 03/24/13, and the Weekend Manager contacted the DON to report the incident. However, the DON did not initiate an investigation of the incident and did not notify the Administrator of the incident. On 03/27/13, the facility's Cooperate Nurse Consultant learned of the incident through review of Resident #4's medical record. The DON and Administrator #2 interviewed RN #8 about the incident prior to the start of her shift on 03/27/13. However, the DON and Administrator #2 allowed RN #8 to continue to provide direct care to residents in the facility during her scheduled twelve (12) hour shift on 03/27/13 and, as a result, failed to ensure residents in the facility were protected from further potential abuse while the facility's investigation was in progress. In addition, the facility failed to ensure four (4) other potential allegations of abuse were thoroughly investigated and reported to the appropriate State Agencies; alleged verbal abuse involving Resident #19; Resident #29 expressing fear of State Registered Nurse Aide (SRNA) #14; Resident #30 being sprayed with cold water and having a towel wrapped around his/her neck; and, Resident #31 being handled roughly by staff while being placed in a chair. The facility's failure to

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0225	(continued... from page 10) immediately report an allegation of abuse, failure to protect residents during the course of an investigation of abuse, and failure to thoroughly investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F225- S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: 1. Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Based on a review of the facility's investigation, dated 02/22/13, and interviews with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM, with Housekeeper #2 on 03/01/13 at 11:47 AM, with SRNA #3 on 03/01/13 at 12:29 PM, with Kentucky Medication Aide (KMA) #1 on 03/01/13 at 12:01 PM, and review of a witness statement provided by SRNA #2 (unable to be reached for interview), LPN #1 was observed to abuse Resident #1. However, no action was immediately taken by the staff who witnessed the abuse to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, when Housekeeper #1 attempted to notify the Social Worker/Abuse Coordinator, as directed in the facility's policy, via phone, but was unable to reach her, and left a message describing what she had witnessed. Housekeeper #1 and Housekeeper #2 stated they did not immediately report the abuse due to being nervous, scared, and did not know what to do, since the abuse had been committed by the Charge Nurse. Housekeeper #1 stated after leaving the voice message for the Abuse Coordinator, she observed the Staff Development Coordinator in the facility and immediately reported what she had witnessed to her. An interview conducted with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, on 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and was approached by Housekeepers #1 and #2 at approximately 11:40 AM, reporting the incident they witnessed concerning Resident #1 and LPN #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements, but took no action to protect residents in the facility from further abuse by the LPN. The Staff Development Coordinator/Nurse Manager stated she did not have the authority to remove LPN #1 (Charge Nurse) from patient care, stating only the Administrator, Social Worker/Abuse Coordinator, or Director of Nursing had that authority. The Staff Development Coordinator/Nurse Manager stated she also attempted to contact the Social Worker/Abuse Coordinator, time unknown, but was unable to reach her and left a voice message. The Staff Development Coordinator/Nurse Manager stated she was unable to notify the DON of the alleged abuse due to not having access to her current phone number. According to the Staff Development Coordinator/Nurse Manager, LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse was observed) when the Staff Development Coordinator/Nurse Manager contacted the facility's Nurse Consultant via telephone and was instructed to suspend LPN #1, the Charge Nurse. However, review of the facility's policy revealed residents would receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed once she discovered and listened to the voice messages from Housekeeper #1 and the Staff Development Coordinator/Nurse Manager on 02/17/13 (time unknown) she went to the facility to assist with the investigation. According to the Social Worker/Abuse Coordinator staff was required to report any allegations of abuse to the Abuse Coordinator (herself), the Administrator, the DON, or the Charge Nurse. However, the facility had no specific detailed reporting procedure such as an on call system, to ensure staff was able to report abuse as the facility policy directs. The Social Worker/Abuse Coordinator stated there was no written order of whom to report abuse to, and staff would have to go through the individuals listed in the policy until one was reached. The Social Worker/Abuse Coordinator further stated she was allowed to remove alleged perpetrators from resident care and she was unaware if another Nurse had the authority to remove alleged perpetrators from direct care after an allegation of abuse had been alleged. Interview further revealed when an allegation of abuse was made she, the DON, and the Administrator, performed the investigation. According to the Social Worker/Abuse Coordinator depending on who got to the facility first, the others would just see who did what and assist with the investigation. The Social Worker/Abuse Coordinator stated the Administrator was ultimately responsible for the decision to determine if a staff member had committed an abusive act toward a resident, and made decisions regarding all disciplinary action. Review of the facility's policy revealed only the Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Administrator #1 stated in an interview conducted on 02/28/13 at 5:20 PM that his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. According to Administrator #1 when he interviewed LPN #1, she did confirm Resident #1 was crying and yelling at the Nurses' station and she (the Charge Nurse) instructed staff to leave the resident up in the chair, but explained that it was to observe the resident. Administrator #1 also acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson. Additionally, the Abuse Coordinator had reported that although she had been unable to get specifics of the alleged incident from Resident #1 due to (his/her) impaired cognition, an alert and oriented resident had reported witnessing LPN #1 being inappropriate and rude to another resident previously. However, after considering all the information that had been obtained during the investigation, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1, and therefore unsubstantiated the allegation, and took no further disciplinary action against LPN #1 in regard to the alleged abuse to Resident #1. Review of the facility's abuse policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. At the time of the investigation, LPN #1, the Charge Nurse, was no longer employed by the facility, and attempts to interview her were unsuccessful. 2. Review of the medical record revealed the facility admitted Resident #29 on 03/18/10 with [DIAGNOSES REDACTED]. A list of residents assessed by the facility to be alert, oriented and interviewable was provided on 04/02/13. According to the list, the facility had assessed Resident #29 to be alert, oriented, and interviewable. Resident #29 was observed sitting in a wheelchair in the facility dining room on 04/05/13 at 5:50 PM. Interview conducted on 04/05/13, at 5:50 PM with Resident #29 revealed he/she was afraid of a staff person (SRNA #14). The resident stated SRNA #14 had touched his/her breast when the SRNA hugged the resident approximately 2-3 months ago, and would come into the resident's room without knocking when the resident was disrobed. Resident #29 stated he/she reported the incident that occurred 2-3 months ago to the facility's Social Worker/Abuse Coordinator at the time the incident occurred. The resident stated SRNA #14 had been moved to another area in the facility after he/she reported the incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM, revealed Resident #29 reported to her on 03/01/13 that SRNA #14 had touched the resident's breast and, although Resident #29 reportedly did not feel SRNA #14's action was abuse, the resident felt the his actions were inappropriate. According to the Social Worker/Abuse Coordinator, she had the responsibility to investigate allegations of abuse, to report the allegation to the appropriate state agencies, and to provide administrative staff a report of her findings. The Social Worker/Abuse Coordinator stated on 03/01/13, she and Administrator #1 talked with Resident #29 regarding the reported

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F 0225	(continued... from page 11) incident and informed Resident #29 that SRNA #14 would be reassigned to another area in the facility. The Social Worker/Abuse Coordinator stated she obtained verbal statements from Resident #29; Resident #29's daughter; and SRNA #14; and a written statement from a staff Nurse that had been assigned to the Seasons unit at the time the resident reported the incident. The Social Worker/Abuse Coordinator stated as a result of the allegation made by Resident #29, SRNA #14 was reassigned to another unit of the facility and was permitted to continue to provide direct care to residents. In addition, the Social Worker/Abuse Coordinator stated she had not considered the incident to be possible abuse; did not conduct further investigation of the allegation; and did not report the incident to the appropriate state agencies. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the Social Worker/Abuse Coordinator, as part of her responsibilities of abuse investigations, she was responsible to remove the alleged perpetrator from resident care and to provide administrative staff the results of her investigation. Administrator #1 was no longer employed as Administrator of the facility and an interview could not be obtained with Administrator #1. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was also currently acting as the facility's Administrator. The Vice President of Operations stated although he was not aware of the incident involving Resident #29, he would attempt to locate the facility's investigation. Continued interview with the Vice President of Operations on 04/05/13 at 7:30 PM revealed SRNA #14 had continued to work at the facility and was working on 04/05/13 when Resident #29 reported the incident to the surveyor. According to the Vice President of Operations, the facility's investigation of the incident consisted of the interviews that had been obtained by the Social Worker/Abuse Coordinator. The Vice President of Operations stated effective 04/05/13 SRNA #14 had been suspended from employment pending further investigation of the incident. The Vice President of Operations stated he did recall Administrator #1 telling him SRNA #14 had been moved to another area of the facility to work due to a resident telling staff he/she did not want SRNA #14 providing their care. However, the Vice President of Operations stated he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. A review of a facility's investigation revealed on 03/24/13, Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. According to investigation witness statements and an investigation was started on 03/24/13 by the facility's Social Worker/Abuse Coordinator. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident. Additional review on 04/09/13 revealed the facility had not completed the investigation and had failed to report the allegation to the appropriate State Agencies until 04/09/13, sixteen (16) days after the alleged incident was reported. In addition, there was no evidence the alleged perpetrator had been suspended. However, the facility's policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the initial report of the allegation dated 04/09/13, revealed that SRNA #13 was not on duty, the facility had attempted to contact SRNA #13, and SRNA #13 would be suspended and not allowed to work until the investigation had cleared the SRNA of the allegation. A review of the facility's investigation log revealed no entry regarding Resident #30. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed, on 04/08/13, the Social Worker/Abuse Coordinator informed the Administrator of the allegation of abuse that had occurred on 03/22/13 and involved Resident #30. According to the Social Worker/Abuse Coordinator, it was the Social Worker/Abuse Coordinator's responsibility to report the allegation to the Administrator and the Director of Nursing. In addition, the Social Worker/Abuse Coordinator stated, the facility's investigation of the allegation that had reportedly occurred on 03/22/13 had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was aware the Social Worker/Abuse Coordinator was talking with Resident #30 on 03/24/13, however; was not aware of an abuse allegation. According to Administrator #2 he was not aware of the allegation of abuse had not been thoroughly investigated and reported as required until the investigation file was found on 04/08/13. 4. Interview with facility Administrator #2 on 03/28/13 at 1:50 PM revealed there had been an allegation of abuse that he planned to report to the appropriate State Agencies. Administrator #2 stated the incident occurred on 03/24/13, was reported on 03/27/13, and the facility was in the process of conducting an investigation. According to Administrator #2, a resident said a Nurse was mean to her/him, but no abuse occurred. Administrator #2 further stated the DON was aware of the allegation on 03/24/13, the date of the alleged abuse, and confirmed an investigation of the incident had not been initiated on 03/24/13 by the facility. Review of an investigation conducted by the facility dated 04/01/13 revealed on 03/24/13 Resident #4 alleged RN #8 was mean to the resident and the resident did not want the Nurse to provide care for her/him. According to the investigation Resident #8 was interviewed on 03/28/13, and reported no one was mean to her/him. The investigation also revealed the resident reported one of the women was mean to her, and stated it was RN #8; however, documentation in the report revealed the resident stated he/she didn't really mean it. Further review of the investigation revealed RN #8 verified Resident #4 had told her that she was mean to the resident on 03/24/13. Based on the facility's investigation the facility unsubstantiated abuse based on the resident's moderately impaired cognitive ability. Review of Resident #4's medical record revealed on 02/01/13 the facility assessed the resident's cognition level as moderately impaired when a significant change in status Minimum Data Set (MDS) assessment had been completed. Interview with Resident #4 on 03/29/13 at 4:00 PM, revealed the resident did not remember the date but stated a few days ago, he/she needed to go to the restroom during the night and turned the call light on to alert staff. Resident #4 stated he/she could not wait and went to the restroom alone. According to Resident #4, RN #8 came in and started telling the resident not to get up unassisted and to wait for help. Resident #4 stated RN #8 was being loud and the resident did not like it. The resident stated he/she told the RN she was being mean; that the resident did not want the RN to provide care for him/her; and, not to come back into the resident's room. Resident #4 stated that later in the morning, he/she told RN #8 that he/she was sorry and the resident did not think the RN was mean. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on 03/24/13, around midnight, Resident #4 rang the call light and the RN went into the room. The RN found the resident in the restroom and instructed the resident to wait for assistance before getting up. According to the RN, the resident became angry and upset and yelled at the RN don't fuss, don't quarrel. RN #8 further stated she went into Resident #8's room again between 2:00 AM and 4:00 AM when the resident's call light was sounding and the resident told the RN he/she did not want the RN to take care of her/him anymore, and stated they could not get along and the resident did not want the Nurse coming in the resident's room anymore. RN #8 further stated around 6:00 AM on 03/24/13 Resident #4 told her she could provide care for her and the resident did not think the RN was mean. Further interview revealed the RN had informed in a casual way RN #9 on B wing of what the resident stated and SRNA #14 and #15 were also aware of Resident #4 being upset with RN #8. However, according to RN #8 she did not inform the DON or Administrator of the incident. Further interview revealed on 03/27/13 around 6:00 PM the DON called and asked the RN to come in early for work. RN #8 stated when she arrived, the DON asked her about the incident on 03/24/13. RN #8 stated she explained the incident and the DON informed her it should have been reported to the DON and Administrator as an allegation of abuse. RN #8 stated after speaking with the DON on 03/27/13 she went out on the floor and worked her twelve (12) hours scheduled shift. Interview with RN #9 on 03/29/13 at 8:02 PM revealed he did remember RN #8 coming to B wing on the morning of 03/24/13 crying. However, he did not remember anything related to Resident #4. Interview with SRNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, RN #8 informed her about the incident with Resident #4. According to SRNA #14 she did not hear the exchange between RN #8 and the resident. SRNA #14 stated she should have reported the incident to another Nurse but it didn't enter her mind to do that. Interview with SRNA #15 on 03/29/13 at 2:34 PM revealed on the morning of 03/24/13 the SRNA came to work at 5:00 AM and RN #8 informed her about the incident between the RN and Resident #4. SRNA #15 stated she did not report the information to the DON or Administrator as she had been instructed to. Interview with RN #4 on 03/29/13 at 7:35 PM revealed she worked on the morning of 03/24/13. According to RN #4, RN #8 informed her during change of shift of the incident between the RN and Resident #8. RN #4 stated RN #8 informed her she had documented the incident in the resident's Nurse's Notes and did not know what else to do about it. RN #4 further stated around 9:00 AM on 03/24/13 she reported the incident to the Weekend Manager because it was charted in the Nurse's Notes; in case there was a need to open an investigation. RN

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NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET** **BEATTYVILLE, KY 41311**	

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F 0225	(continued... from page 12) #4 went on to state if it had not been charted she wouldn't have been so concerned about reporting it. Further interview revealed RN #4 did not report the incident to the DON or Administrator because she didn't see any immediate harm. RN #4 stated she didn't feel abuse occurred, since the resident was fine, everything was fine, and since RN #8 did not go back into Resident #4's room. Interview with the Weekend Manager, who was the Dietary Manager, on 03/28/13 at 6:41 PM, revealed she was the Manager on Duty on Sunday 03/24/13. When she came in that morning she went to each Nurse's station to talk with Nurses. According to the Weekend Manager, RN #4 informed her of the incident that transpired between RN #8 and Resident #4 during the early morning. The Weekend Manager stated she called the DON around 10:00 AM on 03/24/13 to inform her of the incident. The Weekend Manager stated the DON told her the way the situation was handled was fine since Resident #4 told RN #8 she did not think the RN was mean. The Weekend Manager stated she did not pursue an investigation after speaking with the DON, nor did she report the incident to the Administrator. Interview with the DON on 04/02/13 at 8:45 PM revealed she was aware of the incident between Resident #4 and RN #8 that had occurred on 03/24/13. She stated the Weekend Manager had informed her of the situation on 03/24/13 and she did not give the Weekend Manager any further instructions. However, the DON did not initiate an investigation nor did she notify the Administrator. The DON stated on 03/27/13, the Corporate Nurse Consultant contacted her regarding the incident after she had read it in the Nurse's Notes. The DON stated, at that time, she called RN #8 and asked her to come to the facility for interview. The DON further stated she and Administrator #2 allowed the RN to continue working on 03/27/13 after interviewing her and prior to the finishing the investigation that was initiated on 03/27/13. The DON stated after she and Administrator #2 interviewed RN #8, they determined abuse had not occurred. Interview with the Cooperate Nurse Consultant on 03/28/13 at 7:45 PM revealed on 03/27/13 she was training another corporate staff member while performing audits of resident medical records. According to the Corporate Nurse Consultant, the trainee was reviewing Resident #4's chart and discovered Nurses' Notes from 03/24/13 regarding the incident between the resident and RN #8. Further interview revealed she called the DON, who was in the building, to question if she was aware of the incident. The DON informed her she was, but had forgotten to investigate it and report it to anyone else. The Cooperate Nurse Consultant stated on 03/27/13 she called the Chief Nurse Executive to inform her of the findings. The Chief Nurse Executive informed her to interview RN #8 and obtain a statement. Interview further revealed, after the interview had been conducted, she did not conduct a follow-up to ensure an investigation had been initiated and residents were protected. The Cooperate Nurse Consultant stated she was not aware RN #8 was permitted to work the shift on the evening of 03/27/13. Interview with the Chief Nurse Executive on 03/29/13 at 3:25 PM revealed she did receive a call on 03/27/13 concerning the incident between RN #8 and Resident #4. She instructed the Cooperate Nurse Consultant to obtain a statement from the RN and that she would notify the Cooperate Regional Controller, who was in charge while the Vice President of Operations was away. Further interview revealed she did notify the Corporate Regional Controller who stated this is not good, and stated she would notify the Administrator. According to the Chief Nurse Executive, even though she thought they needed to suspend the Nurse, she provided no additional input into the investigation. Interview with the Cooperate Regional Controller on 03/29/13 at 2:15 PM revealed she was notified on 03/27/13 by the Chief Nurse Executive of the incident between Resident #4 and RN #8. She further stated she informed the Chief Nurse Executive that she would notify the Administrator. Further interview revealed she was not aware RN #8 was permitted to work on the evening of 03/27/13 because, at that point, the investigation had just been initiated. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM, revealed he became aware of the incident on 03/27/13 at approximately 5:40 PM and went to speak with the DON regarding the incident. According to Administrator #2 the DON informed him she had forgotten to notify him of the allegation and failed to initiate an investigation into the incident. Administrator #2 further stated on 03/27/13 when the DON acknowledged the incident and reported she had forgotten to conduct an investigation; the DON called RN #8 into the office to question her regarding the incident. Administrator #2 stated although he sat in during the interview, he was half paying attention. Administrator #2 further stated he was aware the RN was permitted to work after being interviewed on 03/27/13 while the investigation was in progress. However, review of the facility's abuse policy revealed the resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Further interview with Administrator #2 revealed he did not think it (the allegation) was reportable, he stated in my heart of hearts I have gotten to know the little girl (RN #8) while I've been here, I just didn't feel it was true and reportable. He stated as of 03/29/13 RN #8 was on suspension and the decision to let her work on
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to have an effective system to ensure all allegations of abuse were reported immediately to the Administrator of the facility, failed to protect residents after an allegation of abuse, and failed to ensure all alleged violations were thoroughly investigated for six of twenty-nine sampled residents (Resident #1, #4, #19, #29, #30, and #31). On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the Nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker/Abuse Coordinator and left a voice mail message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing (DON), and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. According to the facility investigation, dated 02/22/13, after the investigation was completed the facility unsubstantiated that abuse occurred. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223.) In addition, on the morning of 03/24/13, at approximately 12:00 AM, Resident #4 reported to Registered Nurse (RN) #8 that RN #8 was mean to the resident; that the resident did not want RN #8 to provide care for the resident anymore; and, asked RN #8 to not come back into the resident's room. RN #8 documented the incident in Resident #4's medical record and reported the incident to the oncoming Nurse (RN #4) at 7:00 AM. RN #4 reported the incident to the Weekend Manager on 03/24/13, and the Weekend Manager contacted the DON to report the incident. However, the DON did not initiate an investigation of the incident and did not notify the Administrator of the incident. On 03/27/13, the facility's Cooperate Nurse Consultant learned of the incident through review of Resident #4's medical record. The DON and Administrator #2 interviewed RN #8 about the incident prior to the start of her shift on 03/27/13. However, the DON and Administrator #2 allowed RN #8 to continue to provide direct care to residents in the facility during her scheduled twelve (12) hour shift on 03/27/13 and, as a result, failed to ensure residents in the facility were protected from further potential abuse while the facility's investigation was in progress. In addition, the facility failed to ensure four (4) other potential allegations of abuse were thoroughly investigated and reported to the appropriate State Agencies; alleged verbal abuse involving Resident #19; Resident #29 expressing fear of State Registered Nurse Aide (SRNA) #14; Resident #30 being sprayed with cold water and having a towel wrapped around his/her neck; and, Resident #31 being handled roughly by staff while being placed in a chair. The facility's failure to immediately report an allegation of abuse, failure to protect residents during the course of an investigation of abuse, and failure to thoroughly investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to

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F 0225	(continued... from page 13) abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F225- S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: 1. Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Based on a review of the facility's investigation, dated 02/22/13, and interviews with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM, with Housekeeper #2 on 03/01/13 at 11:47 AM, with SRNA #3 on 03/01/13 at 12:29 PM, with Kentucky Medication Aide (KMA) #1 on 03/01/13 at 12:01 PM, and review of a witness statement provided by SRNA #2 (unable to be reached for interview), LPN #1 was observed to abuse Resident #1. However, no action was immediately taken by the staff who witnessed the abuse to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, when Housekeeper #1 attempted to notify the Social Worker/Abuse Coordinator, as directed in the facility's policy, via phone, but was unable to reach her, and left a message describing what she had witnessed. Housekeeper #1 and Housekeeper #2 stated they did not immediately report the abuse due to being nervous, scared, and did not know what to do, since the abuse had been committed by the Charge Nurse. Housekeeper #1 stated after leaving the voice message for the Abuse Coordinator, she observed the Staff Development Coordinator in the facility and immediately reported what she had witnessed to her. An interview conducted with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, on 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and was approached by Housekeepers #1 and #2 at approximately 11:40 AM, reporting the incident they witnessed concerning Resident #1 and LPN #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements, but took no action to protect residents in the facility from further abuse by the LPN. The Staff Development Coordinator/Nurse Manager stated she did not have the authority to remove LPN #1 (Charge Nurse) from patient care, stating only the Administrator, Social Worker/Abuse Coordinator, or Director of Nursing had that authority. The Staff Development Coordinator/Nurse Manager stated she also attempted to contact the Social Worker/Abuse Coordinator, time unknown, but was unable to reach her and left a voice message. The Staff Development Coordinator/Nurse Manager stated she was unable to notify the DON of the alleged abuse due to not having access to her current phone number. According to the Staff Development Coordinator/Nurse Manager, LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse was observed) when the Staff Development Coordinator/Nurse Manager contacted the facility's Nurse Consultant via telephone and was instructed to suspend LPN #1, the Charge Nurse. However, review of the facility's policy revealed residents would receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed once she discovered and listened to the voice messages from Housekeeper #1 and the Staff Development Coordinator/Nurse Manager on 02/17/13 (time unknown) she went to the facility to assist with the investigation. According to the Social Worker/Abuse Coordinator staff was required to report any allegations of abuse to the Abuse Coordinator (herself), the Administrator, the DON, or the Charge Nurse. However, the facility had no specific detailed reporting procedure such as an on call system, to ensure staff was able to report abuse as the facility policy directs. The Social Worker/Abuse Coordinator stated there was no written order of whom to report abuse to, and staff would have to go through the individuals listed in the policy until one was reached. The Social Worker/Abuse Coordinator further stated she was allowed to remove alleged perpetrators from resident care and she was unaware if another Nurse had the authority to remove alleged perpetrators from direct care after an allegation of abuse had been alleged. Interview further revealed when an allegation of abuse was made she, the DON, and the Administrator, performed the investigation. According to the Social Worker/Abuse Coordinator depending on who got to the facility first, the others would just see who did what and assist with the investigation. The Social Worker/Abuse Coordinator stated the Administrator was ultimately responsible for the decision to determine if a staff member had committed an abusive act toward a resident, and made decisions regarding all disciplinary action. Review of the facility's policy revealed only the Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Administrator #1 stated in an interview conducted on 02/28/13 at 5:20 PM that his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. According to Administrator #1 when he interviewed LPN #1, she did confirm Resident #1 was crying and yelling at the Nurses' station and she (the Charge Nurse) instructed staff to leave the resident up in the chair, but explained that it was to observe the resident. Administrator #1 also acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson. Additionally, the Abuse Coordinator had reported that although she had been unable to get specifics of the alleged incident from Resident #1 due to (his/her) impaired cognition, an alert and oriented resident had reported witnessing LPN #1 being inappropriate and rude to another resident previously. However, after considering all the information that had been obtained during the investigation, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1, and therefore unsubstantiated the allegation, and took no further disciplinary action against LPN #1 in regard to the alleged abuse to Resident #1. Review of the facility's abuse policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. At the time of the investigation, LPN #1, the Charge Nurse, was no longer employed by the facility, and attempts to interview her were unsuccessful. 2. Review of the medical record revealed the facility admitted Resident #29 on 03/18/10 with [DIAGNOSES REDACTED]. A list of residents assessed by the facility to be alert, oriented and interviewable was provided on 04/02/13. According to the list, the facility had assessed Resident #29 to be alert, oriented, and interviewable. Resident #29 was observed sitting in a wheelchair in the facility dining room on 04/05/13 at 5:50 PM. Interview conducted on 04/05/13, at 5:50 PM with Resident #29 revealed he/she was afraid of a staff person (SRNA #14). The resident stated SRNA #14 had touched his/her breast when the SRNA hugged the resident approximately 2-3 months ago, and would come into the resident's room without knocking when the resident was disrobed. Resident #29 stated he/she reported the incident that occurred 2-3 months ago to the facility's Social Worker/Abuse Coordinator at the time the incident occurred. The resident stated SRNA #14 had been moved to another area in the facility after he/she reported the incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM, revealed Resident #29 reported to her on 03/01/13 that SRNA #14 had touched the resident's breast and, although Resident #29 reportedly did not feel SRNA #14's action was abuse, the resident felt the his actions were inappropriate. According to the Social Worker/Abuse Coordinator, she had the responsibility to investigate allegations of abuse, to report the allegation to the appropriate state agencies, and to provide administrative staff a report of her findings. The Social Worker/Abuse Coordinator stated on 03/01/13, she and Administrator #1 talked with Resident #29 regarding the reported incident and informed Resident #29 that SRNA #14 would be reassigned to another area in the facility. The Social Worker/Abuse Coordinator stated she obtained verbal statements from Resident #29; Resident #29's daughter; and SRNA #14; and a written statement from a staff Nurse that had been assigned to the Seasons unit at the time the resident reported the

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F 0225	(continued... from page 14) incident. The Social Worker/Abuse Coordinator stated as a result of the allegation made by Resident #29, SRNA #14 was reassigned to another unit of the facility and was permitted to continue to provide direct care to residents. In addition, the Social Worker/Abuse Coordinator stated she had not considered the incident to be possible abuse; did not conduct further investigation of the allegation; and did not report the incident to the appropriate state agencies. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the Social Worker/Abuse Coordinator, as part of her responsibilities of abuse investigations, she was responsible to remove the alleged perpetrator from resident care and to provide administrative staff the results of her investigation. Administrator #1 was no longer employed as Administrator of the facility and an interview could not be obtained with Administrator #1. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was also currently acting as the facility's Administrator. The Vice President of Operations stated although he was not aware of the incident involving Resident #29, he would attempt to locate the facility's investigation. Continued interview with the Vice President of Operations on 04/05/13 at 7:30 PM revealed SRNA #14 had continued to work at the facility and was working on 04/05/13 when Resident #29 reported the incident to the surveyor. According to the Vice President of Operations, the facility's investigation of the incident consisted of the interviews that had been obtained by the Social Worker/Abuse Coordinator. The Vice President of Operations stated effective 04/05/13 SRNA #14 had been suspended from employment pending further investigation of the incident. The Vice President of Operations stated he did recall Administrator #1 telling him SRNA #14 had been moved to another area of the facility to work due to a resident telling staff he/she did not want SRNA #14 providing their care. However, the Vice President of Operations stated he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. A review of a facility's investigation revealed on 03/24/13, Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. According to investigation witness statements and an investigation was started on 03/24/13 by the facility's Social Worker/Abuse Coordinator. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident. Additional review on 04/09/13 revealed the facility had not completed the investigation and had failed to report the allegation to the appropriate State Agencies until 04/09/13, sixteen (16) days after the alleged incident was reported. In addition, there was no evidence the alleged perpetrator had been suspended. However, the facility's policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the initial report of the allegation dated 04/09/13, revealed that SRNA #13 was not on duty, the facility had attempted to contact SRNA #13, and SRNA #13 would be suspended and not allowed to work until the investigation had cleared the SRNA of the allegation. A review of the facility's investigation log revealed no entry regarding Resident #30. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed, on 04/08/13, the Social Worker/Abuse Coordinator informed the Administrator of the allegation of abuse that had occurred on 03/22/13 and involved Resident #30. According to the Social Worker/Abuse Coordinator, it was the Social Worker/Abuse Coordinator's responsibility to report the allegation to the Administrator and the Director of Nursing. In addition, the Social Worker/Abuse Coordinator stated, the facility's investigation of the allegation that had reportedly occurred on 03/22/13 had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was aware the Social Worker/Abuse Coordinator was talking with Resident #30 on 03/24/13, however; was not aware of an abuse allegation. According to Administrator #2 he was not aware of the allegation of abuse had not been thoroughly investigated and reported as required until the investigation file was found on 04/08/13. 4. Interview with facility Administrator #2 on 03/28/13 at 1:50 PM revealed there had been an allegation of abuse that he planned to report to the appropriate State Agencies. Administrator #2 stated the incident occurred on 03/24/13, was reported on 03/27/13, and the facility was in the process of conducting an investigation. According to Administrator #2, a resident said a Nurse was mean to her/him, but no abuse occurred. Administrator #2 further stated the DON was aware of the allegation on 03/24/13, the date of the alleged abuse, and confirmed an investigation of the incident had not been initiated on 03/24/13 by the facility. Review of an investigation conducted by the facility dated 04/01/13 revealed on 03/24/13 Resident #4 alleged RN #8 was mean to the resident and the resident did not want the Nurse to provide care for her/him. According to the investigation Resident #8 was interviewed on 03/28/13, and reported no one was mean to her/him. The investigation also revealed the resident reported one of the women was mean to her, and stated it was RN #8; however, documentation in the report revealed the resident stated he/she didn't really mean it. Further review of the investigation revealed RN #8 verified Resident #4 had told her that she was mean to the resident on 03/24/13. Based on the facility's investigation the facility unsubstantiated abuse based on the resident's moderately impaired cognitive ability. Review of Resident #4's medical record revealed on 02/01/13 the facility assessed the resident's cognition level as moderately impaired when a significant change in status Minimum Data Set (MDS) assessment had been completed. Interview with Resident #4 on 03/29/13 at 4:00 PM, revealed the resident did not remember the date but stated a few days ago, he/she needed to go to the restroom during the night and turned the call light on to alert staff. Resident #4 stated he/she could not wait and went to the restroom alone. According to Resident #4, RN #8 came in and started telling the resident not to get up unassisted and to wait for help. Resident #4 stated RN #8 was being loud and the resident did not like it. The resident stated he/she told the RN she was being mean; that the resident did not want the RN to provide care for him/her; and, not to come back into the resident's room. Resident #4 stated that later in the morning, he/she told RN #8 that he/she was sorry and the resident did not think the RN was mean. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on 03/24/13, around midnight, Resident #4 rang the call light and the RN went into the room. The RN found the resident in the restroom and instructed the resident to wait for assistance before getting up. According to the RN, the resident became angry and upset and yelled at the RN don't fuss, don't quarrel. RN #8 further stated she went into Resident #8's room again between 2:00 AM and 4:00 AM when the resident's call light was sounding and the resident told the RN he/she did not want the RN to take care of her/him anymore, and stated they could not get along and the resident did not want the Nurse coming in the resident's room anymore. RN #8 further stated around 6:00 AM on 03/24/13 Resident #4 told her she could provide care for her and the resident did not think the RN was mean. Further interview revealed the RN had informed in a casual way RN #9 on B wing of what the resident stated and SRNA #14 and #15 were also aware of Resident #4 being upset with RN #8. However, according to RN #8 she did not inform the DON or Administrator of the incident. Further interview revealed on 03/27/13 around 6:00 PM the DON called and asked the RN to come in early for work. RN #8 stated when she arrived, the DON asked her about the incident on 03/24/13. RN #8 stated she explained the incident and the DON informed her it should have been reported to the DON and Administrator as an allegation of abuse. RN #8 stated after speaking with the DON on 03/27/13 she went out on the floor and worked her twelve (12) hours scheduled shift. Interview with RN #9 on 03/29/13 at 8:02 PM revealed he did remember RN #8 coming to B wing on the morning of 03/24/13 crying. However, he did not remember anything related to Resident #4. Interview with SRNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, RN #8 informed her about the incident with Resident #4. According to SRNA #14 she did not hear the exchange between RN #8 and the resident. SRNA #14 stated she should have reported the incident to another Nurse but it didn't enter her mind to do that. Interview with SRNA #15 on 03/29/13 at 2:34 PM revealed on the morning of 03/24/13 the SRNA came to work at 5:00 AM and RN #8 informed her about the incident between the RN and Resident #4. SRNA #15 stated she did not report the information to the DON or Administrator as she had been instructed to. Interview with RN #4 on 03/29/13 at 7:35 PM revealed she worked on the morning of 03/24/13. According to RN #4, RN #8 informed her during change of shift of the incident between the RN and Resident #8. RN #4 stated RN #8 informed her she had documented the incident in the resident's Nurse's Notes and did not know what else to do about it. RN #4 further stated around 9:00 AM on 03/24/13 she reported the incident to the Weekend Manager because it was charted in the Nurse's Notes; in case there was a need to open an investigation. RN #4 went on to state if it had not been charted she wouldn't have been so concerned about reporting it. Further interview revealed RN #4 did not report the incident to the DON or Administrator because she didn't see any immediate harm. RN #4 stated she didn't feel abuse occurred, since the resident was fine, everything was fine, and since RN #8 did not go back

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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F 0225	(continued... from page 15) into Resident #4's room. Interview with the Weekend Manager, who was the Dietary Manager, on 03/28/13 at 6:41 PM, revealed she was the Manager on Duty on Sunday 03/24/13. When she came in that morning she went to each Nurse's station to talk with Nurses. According to the Weekend Manager, RN #4 informed her of the incident that transpired between RN #8 and Resident #4 during the early morning. The Weekend Manager stated she called the DON around 10:00 AM on 03/24/13 to inform her of the incident. The Weekend Manager stated the DON told her the way the situation was handled was fine since Resident #4 told RN #8 she did not think the RN was mean. The Weekend Manager stated she did not pursue an investigation after speaking with the DON, nor did she report the incident to the Administrator. Interview with the DON on 04/02/13 at 8:45 PM revealed she was aware of the incident between Resident #4 and RN #8 that had occurred on 03/24/13. She stated the Weekend Manager had informed her of the situation on 03/24/13 and she did not give the Weekend Manager any further instructions. However, the DON did not initiate an investigation nor did she notify the Administrator. The DON stated on 03/27/13, the Corporate Nurse Consultant contacted her regarding the incident after she had read it in the Nurse's Notes. The DON stated, at that time, she called RN #8 and asked her to come to the facility for interview. The DON further stated she and Administrator #2 allowed the RN to continue working on 03/27/13 after interviewing her and prior to the finishing the investigation that was initiated on 03/27/13. The DON stated after she and Administrator #2 interviewed RN #8, they determined abuse had not occurred. Interview with the Cooperate Nurse Consultant on 03/28/13 at 7:45 PM revealed on 03/27/13 she was training another corporate staff member while performing audits of resident medical records. According to the Corporate Nurse Consultant, the trainee was reviewing Resident #4's chart and discovered Nurses' Notes from 03/24/13 regarding the incident between the resident and RN #8. Further interview revealed she called the DON, who was in the building, to question if she was aware of the incident. The DON informed her she was, but had forgotten to investigate it and report it to anyone else. The Cooperate Nurse Consultant stated on 03/27/13 she called the Chief Nurse Executive to inform her of the findings. The Chief Nurse Executive informed her to interview RN #8 and obtain a statement. Interview further revealed, after the interview had been conducted, she did not conduct a follow-up to ensure an investigation had been initiated and residents were protected. The Cooperate Nurse Consultant stated she was not aware RN #8 was permitted to work the shift on the evening of 03/27/13. Interview with the Chief Nurse Executive on 03/29/13 at 3:25 PM revealed she did receive a call on 03/27/13 concerning the incident between RN #8 and Resident #4. She instructed the Cooperate Nurse Consultant to obtain a statement from the RN and that she would notify the Cooperate Regional Controller, who was in charge while the Vice President of Operations was away. Further interview revealed she did notify the Corporate Regional Controller who stated this is not good, and stated she would notify the Administrator. According to the Chief Nurse Executive, even though she thought they needed to suspend the Nurse, she provided no additional input into the investigation. Interview with the Cooperate Regional Controller on 03/29/13 at 2:15 PM revealed she was notified on 03/27/13 by the Chief Nurse Executive of the incident between Resident #4 and RN #8. She further stated she informed the Chief Nurse Executive that she would notify the Administrator. Further interview revealed she was not aware RN #8 was permitted to work on the evening of 03/27/13 because, at that point, the investigation had just been initiated. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM, revealed he became aware of the incident on 03/27/13 at approximately 5:40 PM and went to speak with the DON regarding the incident. According to Administrator #2 the DON informed him she had forgotten to notify him of the allegation and failed to initiate an investigation into the incident. Administrator #2 further stated on 03/27/13 when the DON acknowledged the incident and reported she had forgotten to conduct an investigation; the DON called RN #8 into the office to question her regarding the incident. Administrator #2 stated although he sat in during the interview, he was half paying attention. Administrator #2 further stated he was aware the RN was permitted to work after being interviewed on 03/27/13 while the investigation was in progress. However, review of the facility's abuse policy revealed the resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Further interview with Administrator #2 revealed he did not think it (the allegation) was reportable, he stated in my heart of hearts I have gotten to know the little girl (RN #8) while I've been here, I just didn't feel it was true and reportable. He stated as of 03/29/13 RN #8 was on suspension and the decision to let her work on
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to have an effective system to ensure all allegations of abuse were reported immediately to the Administrator of the facility, failed to protect residents after an allegation of abuse, and failed to ensure all alleged violations were thoroughly investigated for six of twenty-nine sampled residents (Resident #1, #4, #19, #29, #30, and #31). On 02/17/13 at approximately 7:35 AM, staff observed Resident #1 sitting in a wheelchair located in the dining room next to the Nurses' station, crying in pain, and requesting to go to bed. Licensed Practical Nurse (LPN) #1 refused to allow staff to take Resident #1 to bed and stated the resident would remain seated in the wheelchair until the resident quit crying, hollering, and/or whining. LPN #1 placed a radio near Resident #1's head and turned up the volume. According to interviews, staff attempted to report the alleged abuse to the Social Worker/Abuse Coordinator, in accordance with facility policy; however, staff was unable to contact the Social Worker/Abuse Coordinator and left a voice mail message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, Director of Nursing (DON), and Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. According to the facility investigation, dated 02/22/13, after the investigation was completed the facility unsubstantiated that abuse occurred. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223.) In addition, on the morning of 03/24/13, at approximately 12:00 AM, Resident #4 reported to Registered Nurse (RN) #8 that RN #8 was mean to the resident; that the resident did not want RN #8 to provide care for the resident anymore; and, asked RN #8 to not come back into the resident's room. RN #8 documented the incident in Resident #4's medical record and reported the incident to the oncoming Nurse (RN #4) at 7:00 AM. RN #4 reported the incident to the Weekend Manager on 03/24/13, and the Weekend Manager contacted the DON to report the incident. However, the DON did not initiate an investigation of the incident and did not notify the Administrator of the incident. On 03/27/13, the facility's Cooperate Nurse Consultant learned of the incident through review of Resident #4's medical record. The DON and Administrator #2 interviewed RN #8 about the incident prior to the start of her shift on 03/27/13. However, the DON and Administrator #2 allowed RN #8 to continue to provide direct care to residents in the facility during her scheduled twelve (12) hour shift on 03/27/13 and, as a result, failed to ensure residents in the facility were protected from further potential abuse while the facility's investigation was in progress. In addition, the facility failed to ensure four (4) other potential allegations of abuse were thoroughly investigated and reported to the appropriate State Agencies; alleged verbal abuse involving Resident #19; Resident #29 expressing fear of State Registered Nurse Aide (SRNA) #14; Resident #30 being sprayed with cold water and having a towel wrapped around his/her neck; and, Resident #31 being handled roughly by staff while being placed in a chair. The facility's failure to immediately report an allegation of abuse, failure to protect residents during the course of an investigation of abuse, and failure to thoroughly investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible

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NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F225- S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: 1. Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Based on a review of the facility's investigation, dated 02/22/13, and interviews with Housekeeper #1 on 02/28/13 at 12:17 PM and again on 03/04/13 at 11:37 AM, with Housekeeper #2 on 03/01/13 at 11:47 AM, with SRNA #3 on 03/01/13 at 12:29 PM, with Kentucky Medication Aide (KMA)
#1 on 03/01/13 at 12:01 PM, and review of a witness statement provided by SRNA #2 (unable to be reached for interview), LPN #1 was observed to abuse Resident #1. However, no action was immediately taken by the staff who witnessed the abuse to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, when Housekeeper #1 attempted to notify the Social Worker/Abuse Coordinator, as directed in the facility's policy, via phone, but was unable to reach her, and left a message describing what she had witnessed. Housekeeper #1 and Housekeeper #2 stated they did not immediately report the abuse due to being nervous, scared, and did not know what to do, since the abuse had been committed by the Charge Nurse. Housekeeper #1 stated after leaving the voice message for the Abuse Coordinator, she observed the Staff Development Coordinator in the facility and immediately reported what she had witnessed to her. An interview conducted with the Staff Development Coordinator/Nurse Manager on 02/28/13 at 5:35 PM, on 03/04/13 at 11:07 AM, and again on 03/05/13 at 4:45 PM revealed she was at the facility on 02/17/13 and was approached by Housekeepers #1 and #2 at approximately 11:40 AM, reporting the incident they witnessed concerning Resident #1 and LPN #1. The Staff Development Coordinator/Nurse Manager stated she proceeded to talk with other staff related to the incident and had staff fill out witness statements, but took no action to protect residents in the facility from further abuse by the LPN. The Staff Development Coordinator/Nurse Manager stated she did not have the authority to remove LPN #1 (Charge Nurse) from patient care, stating only the Administrator, Social Worker/Abuse Coordinator, or Director of Nursing had that authority. The Staff Development Coordinator/Nurse Manager stated she also attempted to contact the Social Worker/Abuse Coordinator, time unknown, but was unable to reach her and left a voice message. The Staff Development Coordinator/Nurse Manager stated she was unable to notify the DON of the alleged abuse due to not having access to her current phone number. According to the Staff Development Coordinator/Nurse Manager, LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse was observed) when the Staff Development Coordinator/Nurse Manager contacted the facility's Nurse Consultant via telephone and was instructed to suspend LPN #1, the Charge Nurse. However, review of the facility's policy revealed residents would receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM revealed once she discovered and listened to the voice messages from Housekeeper #1 and the Staff Development Coordinator/Nurse Manager on 02/17/13 (time unknown) she went to the facility to assist with the investigation. According to the Social Worker/Abuse Coordinator staff was required to report any allegations of abuse to the Abuse Coordinator (herself), the Administrator, the DON, or the Charge Nurse. However, the facility had no specific detailed reporting procedure such as an on call system, to ensure staff was able to report abuse as the facility policy directs. The Social Worker/Abuse Coordinator stated there was no written order of whom to report abuse to, and staff would have to go through the individuals listed in the policy until one was reached. The Social Worker/Abuse Coordinator further stated she was allowed to remove alleged perpetrators from resident care and she was unaware if another Nurse had the authority to remove alleged perpetrators from direct care after an allegation of abuse had been alleged. Interview further revealed when an allegation of abuse was made she, the DON, and the Administrator, performed the investigation. According to the Social Worker/Abuse Coordinator depending on who got to the facility first, the others would just see who did what and assist with the investigation. The Social Worker/Abuse Coordinator stated the Administrator was ultimately responsible for the decision to determine if a staff member had committed an abusive act toward a resident, and made decisions regarding all disciplinary action. Review of the facility's policy revealed only the Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Administrator #1 stated in an interview conducted on 02/28/13 at 5:20 PM that his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. According to Administrator #1 when he interviewed LPN #1, she did confirm Resident #1 was crying and yelling at the Nurses' station and she (the Charge Nurse) instructed staff to leave the resident up in the chair, but explained that it was to observe the resident. Administrator #1 also acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson. Additionally, the Abuse Coordinator had reported that although she had been unable to get specifics of the alleged incident from Resident #1 due to (his/her) impaired cognition, an alert and oriented resident had reported witnessing LPN #1 being inappropriate and rude to another resident previously. However, after considering all the information that had been obtained during the investigation, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1, and therefore unsubstantiated the allegation, and took no further disciplinary action against LPN #1 in regard to the alleged abuse to Resident #1. Review of the facility's abuse policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. At the time of the investigation, LPN #1, the Charge Nurse, was no longer employed by the facility, and attempts to interview her were unsuccessful. 2. Review of the medical record revealed the facility admitted Resident #29 on 03/18/10 with [DIAGNOSES REDACTED]. A list of residents assessed by the facility to be alert, oriented and interviewable was provided on 04/02/13. According to the list, the facility had assessed Resident #29 to be alert, oriented, and interviewable. Resident #29 was observed sitting in a wheelchair in the facility dining room on 04/05/13 at 5:50 PM. Interview conducted on 04/05/13, at 5:50 PM with Resident #29 revealed he/she was afraid of a staff person (SRNA #14). The resident stated SRNA #14 had touched his/her breast when the SRNA hugged the resident approximately 2-3 months ago, and would come into the resident's room without knocking when the resident was disrobed. Resident #29 stated he/she reported the incident that occurred 2-3 months ago to the facility's Social Worker/Abuse Coordinator at the time the incident occurred. The resident stated SRNA #14 had been moved to another area in the facility after he/she reported the incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM, revealed Resident #29 reported to her on 03/01/13 that SRNA #14 had touched the resident's breast and, although Resident #29 reportedly did not feel SRNA #14's action was abuse, the resident felt the his actions were inappropriate. According to the Social Worker/Abuse Coordinator, she had the responsibility to investigate allegations of abuse, to report the allegation to the appropriate state agencies, and to provide administrative staff a report of her findings. The Social Worker/Abuse Coordinator stated on 03/01/13, she and Administrator #1 talked with Resident #29 regarding the reported incident and informed Resident #29 that SRNA #14 would be reassigned to another area in the facility. The Social Worker/Abuse Coordinator stated she obtained verbal statements from Resident #29; Resident #29's daughter; and SRNA #14; and a written statement from a staff Nurse that had been assigned to the Seasons unit at the time the resident reported the incident. The Social Worker/Abuse Coordinator stated as a result of the allegation made by Resident #29, SRNA #14 was reassigned to another unit of the facility and was permitted to continue to provide direct care to residents. In addition, the Social Worker/Abuse Coordinator stated she had not considered the incident to be possible abuse; did not conduct

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F 0225	(continued... from page 17) further investigation of the allegation; and did not report the incident to the appropriate state agencies. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the Social Worker/Abuse Coordinator, as part of her responsibilities of abuse investigations, she was responsible to remove the alleged perpetrator from resident care and to provide administrative staff the results of her investigation. Administrator #1 was no longer employed as Administrator of the facility and an interview could not be obtained with Administrator #1. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was also currently acting as the facility's Administrator. The Vice President of Operations stated although he was not aware of the incident involving Resident #29, he would attempt to locate the facility's investigation. Continued interview with the Vice President of Operations on 04/05/13 at 7:30 PM revealed SRNA #14 had continued to work at the facility and was working on 04/05/13 when Resident #29 reported the incident to the surveyor. According to the Vice President of Operations, the facility's investigation of the incident consisted of the interviews that had been obtained by the Social Worker/Abuse Coordinator. The Vice President of Operations stated effective 04/05/13 SRNA #14 had been suspended from employment pending further investigation of the incident. The Vice President of Operations stated he did recall Administrator #1 telling him SRNA #14 had been moved to another area of the facility to work due to a resident telling staff he/she did not want SRNA #14 providing their care. However, the Vice President of Operations stated he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. A review of a facility's investigation revealed on 03/24/13, Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. According to investigation witness statements and an investigation was started on 03/24/13 by the facility's Social Worker/Abuse Coordinator. However, review of the facility's policy on abuse revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident. Additional review on 04/09/13 revealed the facility had not completed the investigation and had failed to report the allegation to the appropriate State Agencies until 04/09/13, sixteen (16) days after the alleged incident was reported. In addition, there was no evidence the alleged perpetrator had been suspended. However, the facility's policy revealed the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. According to the initial report of the allegation dated 04/09/13, revealed that SRNA #13 was not on duty, the facility had attempted to contact SRNA #13, and SRNA #13 would be suspended and not allowed to work until the investigation had cleared the SRNA of the allegation. A review of the facility's investigation log revealed no entry regarding Resident #30. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed, on 04/08/13, the Social Worker/Abuse Coordinator informed the Administrator of the allegation of abuse that had occurred on 03/22/13 and involved Resident #30. According to the Social Worker/Abuse Coordinator, it was the Social Worker/Abuse Coordinator's responsibility to report the allegation to the Administrator and the Director of Nursing. In addition, the Social Worker/Abuse Coordinator stated, the facility's investigation of the allegation that had reportedly occurred on 03/22/13 had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was aware the Social Worker/Abuse Coordinator was talking with Resident #30 on 03/24/13, however; was not aware of an abuse allegation. According to Administrator #2 he was not aware of the allegation of abuse had not been thoroughly investigated and reported as required until the investigation file was found on 04/08/13. 4. Interview with facility Administrator #2 on 03/28/13 at 1:50 PM revealed there had been an allegation of abuse that he planned to report to the appropriate State Agencies. Administrator #2 stated the incident occurred on 03/24/13, was reported on 03/27/13, and the facility was in the process of conducting an investigation. According to Administrator #2, a resident said a Nurse was mean to her/him, but no abuse occurred. Administrator #2 further stated the DON was aware of the allegation on 03/24/13, the date of the alleged abuse, and confirmed an investigation of the incident had not been initiated on 03/24/13 by the facility. Review of an investigation conducted by the facility dated 04/01/13 revealed on 03/24/13 Resident #4 alleged RN #8 was mean to the resident and the resident did not want the Nurse to provide care for her/him. According to the investigation Resident #8 was interviewed on 03/28/13, and reported no one was mean to her/him. The investigation also revealed the resident reported one of the women was mean to her, and stated it was RN #8; however, documentation in the report revealed the resident stated he/she didn't really mean it. Further review of the investigation revealed RN #8 verified Resident #4 had told her that she was mean to the resident on 03/24/13. Based on the facility's investigation the facility unsubstantiated abuse based on the resident's moderately impaired cognitive ability. Review of Resident #4's medical record revealed on 02/01/13 the facility assessed the resident's cognition level as moderately impaired when a significant change in status Minimum Data Set (MDS) assessment had been completed. Interview with Resident #4 on 03/29/13 at 4:00 PM, revealed the resident did not remember the date but stated a few days ago, he/she needed to go to the restroom during the night and turned the call light on to alert staff. Resident #4 stated he/she could not wait and went to the restroom alone. According to Resident #4, RN #8 came in and started telling the resident not to get up unassisted and to wait for help. Resident #4 stated RN #8 was being loud and the resident did not like it. The resident stated he/she told the RN she was being mean; that the resident did not want the RN to provide care for him/her; and, not to come back into the resident's room. Resident #4 stated that later in the morning, he/she told RN #8 that he/she was sorry and the resident did not think the RN was mean. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on 03/24/13, around midnight, Resident #4 rang the call light and the RN went into the room. The RN found the resident in the restroom and instructed the resident to wait for assistance before getting up. According to the RN, the resident became angry and upset and yelled at the RN don't fuss, don't quarrel. RN #8 further stated she went into Resident #8's room again between 2:00 AM and 4:00 AM when the resident's call light was sounding and the resident told the RN he/she did not want the RN to take care of her/him anymore, and stated they could not get along and the resident did not want the Nurse coming in the resident's room anymore. RN #8 further stated around 6:00 AM on 03/24/13 Resident #4 told her she could provide care for her and the resident did not think the RN was mean. Further interview revealed the RN had informed in a casual way RN #9 on B wing of what the resident stated and SRNA #14 and #15 were also aware of Resident #4 being upset with RN #8. However, according to RN #8 she did not inform the DON or Administrator of the incident. Further interview revealed on 03/27/13 around 6:00 PM the DON called and asked the RN to come in early for work. RN #8 stated when she arrived, the DON asked her about the incident on 03/24/13. RN #8 stated she explained the incident and the DON informed her it should have been reported to the DON and Administrator as an allegation of abuse. RN #8 stated after speaking with the DON on 03/27/13 she went out on the floor and worked her twelve (12) hours scheduled shift. Interview with RN #9 on 03/29/13 at 8:02 PM revealed he did remember RN #8 coming to B wing on the morning of 03/24/13 crying. However, he did not remember anything related to Resident #4. Interview with SRNA #14 on 03/29/13 at 4:45 PM revealed on 03/24/13 between 3:00 AM and 4:00 AM, RN #8 informed her about the incident with Resident #4. According to SRNA #14 she did not hear the exchange between RN #8 and the resident. SRNA #14 stated she should have reported the incident to another Nurse but it didn't enter her mind to do that. Interview with SRNA #15 on 03/29/13 at 2:34 PM revealed on the morning of 03/24/13 the SRNA came to work at 5:00 AM and RN #8 informed her about the incident between the RN and Resident #4. SRNA #15 stated she did not report the information to the DON or Administrator as she had been instructed to. Interview with RN #4 on 03/29/13 at 7:35 PM revealed she worked on the morning of 03/24/13. According to RN #4, RN #8 informed her during change of shift of the incident between the RN and Resident #8. RN #4 stated RN #8 informed her she had documented the incident in the resident's Nurse's Notes and did not know what else to do about it. RN #4 further stated around 9:00 AM on 03/24/13 she reported the incident to the Weekend Manager because it was charted in the Nurse's Notes; in case there was a need to open an investigation. RN #4 went on to state if it had not been charted she wouldn't have been so concerned about reporting it. Further interview revealed RN #4 did not report the incident to the DON or Administrator because she didn't see any immediate harm. RN #4 stated she didn't feel abuse occurred, since the resident was fine, everything was fine, and since RN #8 did not go back into Resident #4's room. Interview with the Weekend Manager, who was the Dietary Manager, on 03/28/13 at 6:41 PM, revealed she was the Manager on Duty on Sunday 03/24/13. When she came in that morning she went to each Nurse's station to talk with Nurses. According to the Weekend Manager, RN #4 informed her of the incident that transpired between RN #8 and Resident #4

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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F 0225	(continued... from page 18) during the early morning. The Weekend Manager stated she called the DON around 10:00 AM on 03/24/13 to inform her of the incident. The Weekend Manager stated the DON told her the way the situation was handled was fine since Resident #4 told RN #8 she did not think the RN was mean. The Weekend Manager stated she did not pursue an investigation after speaking with the DON, nor did she report the incident to the Administrator. Interview with the DON on 04/02/13 at 8:45 PM revealed she was aware of the incident between Resident #4 and RN #8 that had occurred on 03/24/13. She stated the Weekend Manager had informed her of the situation on 03/24/13 and she did not give the Weekend Manager any further instructions. However, the DON did not initiate an investigation nor did she notify the Administrator. The DON stated on 03/27/13, the Corporate Nurse Consultant contacted her regarding the incident after she had read it in the Nurse's Notes. The DON stated, at that time, she called RN #8 and asked her to come to the facility for interview. The DON further stated she and Administrator #2 allowed the RN to continue working on 03/27/13 after interviewing her and prior to the finishing the investigation that was initiated on 03/27/13. The DON stated after she and Administrator #2 interviewed RN #8, they determined abuse had not occurred. Interview with the Cooperate Nurse Consultant on 03/28/13 at 7:45 PM revealed on 03/27/13 she was training another corporate staff member while performing audits of resident medical records. According to the Corporate Nurse Consultant, the trainee was reviewing Resident #4's chart and discovered Nurses' Notes from 03/24/13 regarding the incident between the resident and RN #8. Further interview revealed she called the DON, who was in the building, to question if she was aware of the incident. The DON informed her she was, but had forgotten to investigate it and report it to anyone else. The Cooperate Nurse Consultant stated on 03/27/13 she called the Chief Nurse Executive to inform her of the findings. The Chief Nurse Executive informed her to interview RN #8 and obtain a statement. Interview further revealed, after the interview had been conducted, she did not conduct a follow-up to ensure an investigation had been initiated and residents were protected. The Cooperate Nurse Consultant stated she was not aware RN #8 was permitted to work the shift on the evening of 03/27/13. Interview with the Chief Nurse Executive on 03/29/13 at 3:25 PM revealed she did receive a call on 03/27/13 concerning the incident between RN #8 and Resident #4. She instructed the Cooperate Nurse Consultant to obtain a statement from the RN and that she would notify the Cooperate Regional Controller, who was in charge while the Vice President of Operations was away. Further interview revealed she did notify the Corporate Regional Controller who stated this is not good, and stated she would notify the Administrator. According to the Chief Nurse Executive, even though she thought they needed to suspend the Nurse, she provided no additional input into the investigation. Interview with the Cooperate Regional Controller on 03/29/13 at 2:15 PM revealed she was notified on 03/27/13 by the Chief Nurse Executive of the incident between Resident #4 and RN #8. She further stated she informed the Chief Nurse Executive that she would notify the Administrator. Further interview revealed she was not aware RN #8 was permitted to work on the evening of 03/27/13 because, at that point, the investigation had just been initiated. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM, revealed he became aware of the incident on 03/27/13 at approximately 5:40 PM and went to speak with the DON regarding the incident. According to Administrator #2 the DON informed him she had forgotten to notify him of the allegation and failed to initiate an investigation into the incident. Administrator #2 further stated on 03/27/13 when the DON acknowledged the incident and reported she had forgotten to conduct an investigation; the DON called RN #8 into the office to question her regarding the incident. Administrator #2 stated although he sat in during the interview, he was half paying attention. Administrator #2 further stated he was aware the RN was permitted to work after being interviewed on 03/27/13 while the investigation was in progress. However, review of the facility's abuse policy revealed the resident was to receive measures to ensure his or her immediate safety and well-being following the incident and during the investigation process. The Administrator and/or Director of Nursing and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Further interview with Administrator #2 revealed he did not think it (the allegation) was reportable, he stated in my heart of hearts I have gotten to know the little girl (RN #8) while I've been here, I just didn't feel it was true and reportable. He stated as of 03/29/13 RN #8 was on suspension and the decision to let her work on
F 0226	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and a review of the facility's policy and procedures and investigations, it was determined the facility failed to have an effective system to ensure policy and procedures related to abuse were implemented for six of twenty-nine residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to ensure a suspicion of an incident of abuse was reported immediately, failed to ensure that a thorough investigation was conducted for an alleged incident of abuse involving a staff member, and failed to ensure residents were protected following a report of abuse and during the investigation process. Facility staff failed to ensure an allegation of abuse was reported timely. On 02/17/13, facility staff witnessed Licensed Practical Nurse (LPN) #1, the Charge Nurse, verbally abuse Resident #1 at approximately 7:35 AM. Staff attempted, between 11:30 AM and 12:00 PM, to contact the facility's Social Worker/Abuse Coordinator to report the allegation per the facility's policy. The Social Worker/Abuse Coordinator was unavailable and staff left a voice message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. After receipt of the report of alleged abuse, the facility failed to ensure residents were protected from potential further abuse. The facility's policies and procedures stated the Administrator and/or Director of Nursing (DON) and/or Social Worker were the staff that could make any immediate decisions related to the removal of the alleged abuser from direct care giving. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, the DON, and the Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. After completion of the facility's investigation, Administrator #1 reported as a result of the investigation, interviews, and a review of the witness statements, he could not come to a firm conclusion that abuse had occurred and the allegation of abuse was determined to be unsubstantiated by the facility. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223 and F225.) In addition, interview and record review revealed the facility failed to immediately initiate an investigation, failed to ensure residents were protected from further potential abuse during an investigation, and failed to notify the Administrator and appropriate State Agencies for allegations of potential abuse involving Residents #4, #19, #29, #30, and #31. (Refer to F225.) The facility's failure to have an effective system in place to ensure the development and implementation of policies and procedures to protect residents from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F226 - S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed, any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable

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efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse.
1. A review of the facility's investigation revealed on 02/17/13, staff reported Resident #1 was crying, and wanted to be put to bed. However, based on documentation, staff reported LPN #1 (who was the Charge Nurse) would not allow staff to put the resident to bed due to the resident yelling and crying. The investigation further revealed the LPN was immediately suspended on 02/17/13 pending the outcome of the investigation. Further, during the investigation, other residents were interviewed, and one resident reported he/she had overheard LPN #1 say negative things about another resident at the facility. According to the investigation, dated 02/22/13, the facility did not substantiate that the abuse occurred. During the course of the investigation, attempts were made to contact LPN #1 for interview. However, LPN #1 was no longer employed by the facility and attempts to contact the LPN were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from employment by the facility on 02/25/13 for falsification of documentation. Interview with the Staff Development Coordinator/Unit Manager on 02/28/13 at 5:35 PM and again on 03/04/13 at 11:07 AM revealed she came to the facility on [DATE] at approximately 11:00 AM to do a weekend check. At approximately 11:30 AM-11:40 AM, Housekeepers #1 and
#2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and Resident #1. The Staff Development Coordinator/Unit Manager stated the housekeepers informed her Resident #1 asked to be put to bed and the LPN refused to allow staff to put the resident to bed and that they had attempted to contact the Social Worker/Abuse Coordinator prior to notifying her in accordance with facility policy. The Staff Development Coordinator/Unit Manager stated after the housekeepers spoke with her she went out on the floor, started an investigation, talked to individuals on the unit, and had the staff fill out written statements. She stated she spoke with State Registered Nurse Aides and an Activities Worker and had them fill out witness statements. The Staff Development Coordinator/Unit Manager stated LPN #1 remained on the nursing unit at the nurses' station during the time she initiated the investigation. She stated she did not remove LPN #1 from the floor immediately because she was trying to determine if it was appropriate for her to pull the LPN from the floor. Between 11:30 AM and 12:30 PM she attempted to call the Social Worker/Abuse Coordinator, for further guidance, per the facility policy; however, she was unable to contact her via phone. According to the Staff Development Coordinator/Unit Manager, she then contacted the Facility's Nurse Consultant for further direction, and informed LPN #1 that she was being sent home pending the final investigation. She further stated she did not know if she could remove staff from the floor, and the allegation had to be justifiable to remove facility staff from the floor. Further interview revealed she was not sure what was being reported by the housekeepers was abuse. However, review of the facility's policy revealed any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. In addition, the policy stated the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. However, interview and record review revealed these procedures were not implemented. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM confirmed she had received a voice mail message from one of the facility housekeepers and the Staff Development Coordinator/Nurse Manager on 02/17/13. She stated she came to the facility the same day and assisted with the investigation. Further interview with the Social Worker/Abuse Coordinator on 03/04/13, at 1:25 PM, revealed staff had been trained to report allegations of abuse to her, the DON or the Administrator. The Social Worker/Abuse Coordinator further stated she was not sure if a nurse could remove a staff member from direct resident care in the event an allegation of abuse had been made and staff could not reach Administrative staff. Review of staff training records revealed the last abuse training provided by the facility was in December 2012. Interview with Administrator #1 on 02/28/13 at 5:20 PM, revealed LPN #1 did not have a history of abuse and staff may have misinterpreted the LPN since she was loud by nature. Administrator #1 stated they could not come to a firm conclusion related to abuse, at the conclusion of the investigation, and the facility was not able to substantiate that abuse occurred. Interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility policy instructed staff to seek guidance from him, the DON, or the Social Worker/Abuse Coordinator prior to the removal of the alleged perpetrator after an allegation of abuse was made. Per interview, he was not aware the facility's abuse policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, review of the facility's policy revealed only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Interview with the facility's Vice President of Operations, Chief Nurse Executive, and the Nurse Consultant on 03/04/13 at 5:05 PM, revealed the facility's abuse policy had been developed at the corporate level and they were not aware the policy indicated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact following an allegation of suspected abuse. 2. Interview with Resident #29 on 04/05/13 at 5:50 PM, revealed the resident reported he/she was afraid of SRNA #14 because he had touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated SRNA #14 was moved to another area in the facility to work after he/she reported the incident to the facility's Social Worker/Abuse Coordinator. Interview with the Social Worker/Abuse Coordinator on 04/05/13, at 3:30 PM, revealed she also acted as the facility's Abuse Coordinator, was responsible to assist with investigations related to abuse/neglect, and to provide staff education/in-service related to abuse/neglect as indicated. The Social Worker/Abuse Coordinator stated in accordance with facility policy allegations of alleged abuse were to be immediately investigated and reported to the appropriate state agencies. The Social Worker/Abuse Coordinator further stated she had received training from the facility regarding the facility's abuse policies/procedures when she was hired by the facility on 06/20/11, as well as when the policy, which included reporting, investigation, and resident protection of abuse allegations, was revised in March 2013. Further interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she and Administrator #1 talked with the resident about the incident and the resident stated he/she felt the touching incident was inappropriate. The Social Worker/Abuse Coordinator further stated Resident #29 told her he/she did not feel the incident was abuse. According to the Social Worker/Abuse Coordinator, SRNA #14 was moved to another unit in the facility following the report by Resident #29 and was allowed to continue to provide direct care for residents. Although the Social Worker/Abuse Coordinator stated she did obtain statements from Resident #29, the resident's daughter, SRNA #14, and a staff nurse assigned to the Seasons Unit, she did not further investigate the alleged incident. The Social Worker/Abuse Coordinator also stated since the resident stated she did not feel the incident was abuse, she did not report the alleged incident to the State Agencies. An additional interview conducted on 04/09/13, at 11:09 AM, with the Social Worker/Abuse Coordinator revealed she was no longer employed by the facility effective 04/08/13 due to illness. During this interview, the Social Worker/Abuse Coordinator stated she routinely reported all allegations to the DON or Administrator; and they would direct her on the procedures to follow when an allegation of abuse was reported, including investigation, protection, and reporting. The Social Worker/Abuse Coordinator stated she had missed doing some things during the investigation of the incident reported by Resident #29. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was currently acting as the facility's Administrator, and was not aware of the incident involving Resident #29. Further interview with the Vice President of Operations on 04/05/13 at 7:30 PM, revealed SRNA #14 continued to work at the facility in the provision of direct care after Resident #29 had reported the incident and was still providing direct resident care on 04/05/13. However, the Vice President of Operations stated SRNA #14 was suspended from employment after he was informed of the alleged incident on 04/05/13. The Vice President of Operations also confirmed no further investigation had been conducted by the facility of the alleged incident and he could provide no evidence the allegation had been reported to the state agencies as directed by the facility's abuse policy. 3. Review of the facility's investigation, initiated by the facility's Social Worker/Abuse Coordinator on 03/24/13, revealed Resident #30 reported on 03/24/13, that on 03/22/13, from 8:00 PM to 9:00 PM, SRNA #13 had sprayed cold water on the resident while in the shower and had wrapped a sheet too tight around the resident's neck. Continued review revealed the investigation was not completed and the allegation was not reported to the appropriate state agencies until 04/09/13, (sixteen days after the incident was reported). It could not be determined by a review of documentation if the facility had protected residents from further potential abuse while the investigation was being conducted, or if the facility allowed SRNA #13 to continue to provide resident care at the facility. According to the initial report, dated 04/09/13, the facility had attempted to

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F 0226	(continued... from page 20) contact SRNA #13 to inform the SRNA that she would be suspended and not allowed to work until the investigation had been completed. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation of the allegation had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was not aware the allegation of abuse had not been thoroughly investigated and reported as required until the Social Worker/Abuse Coordinator had reported on 04/08/13 that the investigation was not complete. At the time of the interview, Administrator #2 could provide no documentation that any action had taken to ensure residents were protected during the facility's investigation or that the allegation had been reported to the appropriate State Agencies. According to Administrator #2, the allegations were logged in an abuse investigation log at the end of each day. However, review of the facility's investigation log revealed no entry regarding Resident #30. 4. A review of the facility's investigation dated 04/01/13 revealed on 03/27/13, the Administrator was informed that Resident #4 had made an allegation of abuse on 03/24/13, three days prior. According to the investigation, Resident #4 was interviewed on 03/28/13 and reported that no one had been mean to (her/him). When the facility questioned the resident if he/she had alleged someone was mean to him/her the resident stated he/she had told one of the women that. According to the facility's investigation, the resident didn't really mean it. The Social Worker/Abuse Coordinator asked the resident if the woman was RN #8 and the resident stated, Yeah my little nurse. Further review of the investigation revealed RN #8 stated Resident #4 did make the statement on 03/24/13 that she was mean to the resident. RN #8 reported she had told the resident to use the call light for assistance instead of getting up on her own. All residents assessed by the facility to be interviewable were interviewed in regards to their treatment. The investigation concluded the allegation of abuse was unsubstantiated based on Resident #4's moderately impaired cognitive ability. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on the morning of 03/24/13 Resident #4 alleged the RN was mean to the resident and Resident #4 did not want RN #8 to come into the resident's room again or provide care for the resident. RN #8 stated she documented the incident in the nurse's notes, and only thought Resident #4 was upset the morning of 03/24/13. However, RN #8 stated she should have told another nurse; removed herself from the floor; and called the Administrator and DON. RN #8 stated the incident didn't seem like an allegation of abuse. Interview with the DON on 04/02/13 at 8:45 PM revealed she was informed of the allegation against RN #8 on 03/24/13 by the Weekend Manager. She stated she did not give the Weekend Manager any further instructions. The DON stated on 03/25/13 she interviewed Resident #4; got side tracked with something else; and did not notify the Administrator or interview RN #8. The DON stated on 03/27/13, the Corporate Nurse Consultant questioned her related to a nurse's note found in Resident #4's medical record related to the incident. The DON stated she called RN #8 and had her come in to work early on the evening of 03/27/13 to obtain an interview. After interviewing the nurse, the DON and Administrator #2 allowed RN #8 to work her scheduled 12-hour shift. The DON stated since RN #8 and Resident #4 denied the allegation, she and Administrator #2 decided abuse did not occur. However, the DON acknowledged the facility's investigation had not been finished at the time of the interview. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM revealed he became aware of the incident on 03/27/13, at approximately 5:40 PM, and spoke to the DON regarding the incident. Administrator #2 stated the DON informed him she had forgotten to inform him of the allegation of abuse and failed to initiate an investigation related to the allegation. Further, Administrator #2 stated he sat in during the interview between the DON and RN #8; however, he was half paying attention. Administrator #2 initially stated in interview that he was not aware RN #8 had been permitted to work on 03/27/13 and that he didn't ask (DON) why she didn't remove the alleged perpetrator. Continued interview with Administrator #2 revealed he was aware RN #8 had been permitted to work after the interview had been conducted on 03/27/13 while the investigation was in progress. Interview further revealed Administrator #2 did not think it was reportable and stated, In my heart of hearts I have gotten to know the little girl while I've been here, I just didn't feel it was true and reportable. Further interview revealed Administrator #2 had not interviewed the DON regarding the incident and stated the DON had just forgotten to do anything with the information she received on 03/24/13. Administrator #2 stated RN #8 should have reported the incident to another Charge Nurse on 03/24/13; that he should have been notified of the incident; and, that RN #8 should have been sent home on 03/24/13 following the incident. Continued interview with Administrator #2 on 03/29/13 at 4:11 PM revealed he did concur with the DON on 03/27/13 related to allowing RN #8 to work her shift after the resident stated he/she did not want RN #8 to take care of her. Per interview, he and the DON agreed RN #8 could continue to provide resident care. Administrator #2 further stated in hindsight with the facility the way it is right now allowing the RN to continue to work during the investigation was probably a bad decision. 5. Review of the facility's investigation revealed SRNA #1 and SRNA #8 reported to the facility's Social Worker/Abuse Coordinator that on 04/04/13, they overheard a Lab Technician tell Resident #19 It's going to hurt you worse than it will me because I have a needle stuck in your arm. Even though the investigation revealed the incident had been reported immediately to the facility's Social Worker/Abuse Coordinator on 04/04/13, the facility failed to ensure the allegation was immediately reported to the required state agencies until 04/06/13 (two days after the incident was reported). Interview on 04/09/13 at 2:55 PM with the Corporate Nurse Executive who had completed the investigation of the allegation revealed she initially had not considered the allegation reportable. However, the Corporate Nurse Executive stated as a part of the facility's ongoing audits, the allegation was determined to be an allegation of verbal abuse and was reported to the appropriate State Agencies late, on 04/06/13. The Corporate Nurse Executive stated the allegation being reported late was better than not reporting the allegation. 6. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13 of an abuse allegation involving Resident #31 but she could not recall the date of the allegation. An interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 could not recall the allegation regarding Resident #31 that was reported on 04/08/13 and an investigation of the allegation had not been initiated. Continued interview with Administrator #2 on 04/09/13 at 5:00 PM revealed Administrator #2 had discussed the allegation reported by the Social Worker/Abuse Coordinator on 04/08/13 with staff and learned there was an allegation that Resident #31 may have been sat down in a chair too hard by facility staff around 3/17-19/13, but no witness statements or investigation could be found. Review of the facility's investigation log revealed no entry regarding the alleged incident involving Resident #31, which was reported on 04/08/13. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: The allegation of abuse against Resident #31 was reported to appropriate State Agencies on 04/09/13 by Administrator #2. The Interim Social Services Director (SSD) completed an interview with Resident #31 and the resident's daughter on 04/09/13. The facility suspended the alleged perpetrator on 04/09/13. Other employees were interviewed by the Vice President of Human Resources and the Regional Human Resources Director on 04/10/13 to identify if any other staff had observed the alleged perpetrator be rude or rough with any other residents. All residents with a BIMS score of seven or above were interviewed by Regional Staff regarding any concerns with rough or rude treatment and no concerns were identified. The allegation of abuse against Resident #19 was reported to the appropriate State Agencies by the Chief Nurse Executive on 04/06/13. A body audit on Resident #19 was completed by the Regional Nurse Consultant on 04/04/13. Statements were obtained from the lab technician, the alleged perpetrator, on 04/08/13. Statements were obtained on 04/04/13 from two staff members who were present during the alleged abuse. The supervisor of the lab technician was notified by the Chief Nurse Executive on 04/04/13 that the facility would no longer utilize the lab technician. The allegation of abuse against Resident #30 was reported to the appropriate State Agencies on 04/09/13 by Administrator #2. The Administrator and the Interim Social Services Director interviewed Resident #30 on 04/10/13 regarding the alleged abuse incident. Statements were obtained on 04/10/13 from the two staff who were the alleged perpetrators. The two alleged perpetrators were suspended on 04/10/13. An interview was completed by the Chief Operating Officer on 04/09/13 with the Nurse who provided care for Resident #30 on the evening of the alleged incident. Interviews were completed by Regional Staff on 04/09/13 with other residents who reside on the same unit as Resident #30, regarding staff treatment during care, with no concerns identified. The allegation of abuse against Resident #29 was reported to the appropriate State Agencies on 04/05/13 by the Chief Nurse Executive. Administrator #2 and the Interim Social Services Director interviewed Resident #29 on 04/05/13 regarding the alleged abuse. The Regional Nurse completed a body audit on Resident #29 on 04/05/13 with no injuries identified. The alleged perpetrator was interviewed by the Vice President of Human Resources and the Chief Operating Officer along with a statement obtained. The alleged perpetrator was suspended on 04/05/13 along with Administrator #1, who was the facility ' s Administrator at the time of the occurrence, Resident ' s with a BIMS score over 7 was interviewed by Department Managers on 04/05/13 and Regional Staff on 04/05/13 regarding other incidents of inappropriate treatments, with no concerns identified. The

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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F 0226	(continued... from page 21) allegation of abuse by Resident #4 was reported to the appropriate State Agencies on 03/30/13 by Administrator #2 and a final report was submitted on 04/03/13 to the appropriate State Agencies, which unsubstantiated abuse regarding Resident #4. The second allegation of abuse by Resident #4 was submitted to the appropriate State Agencies on 04/09/13. The staff member who was the alleged abuser was suspended during the investigation. A third allegation by Resident #4 was submitted on 04/09/13 regarding a review of an incident report dated 03/28/13 for bruises. The investigation was in progress. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a posttest. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed, will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Independent Contractor initiated continued abuse education regarding identifying, reporting, and ensuring resident safety on 04/11/13. All staff scheduled to work will receive this re-education by 04/12/13. Staff not scheduled to work during that time frame, who work as needed, or who are on leave of absence will receive the education upon returning to work, by Administrator #2, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Staff Development Coordinator, or Regional Staff. On 04/12/13 thirty-four (34) interviews were conducted by the Department Managers (Staffing Coordinator, Dietary Manager, Housekeeping Director) for residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or above to determine their feelings of safety and identify any allegations of mistreatment or abuse. There were no concerns voiced. A body audit was complete for eighty-one (81) residents, there were an additional nine (9) residents who refused a body audit therefore the audit was not performed on those nine (9), by Administrative Nurses (MDS Coordinators, DON, Staff Development Coordinator), on 04/12/13 and regional nurses (Signature Care Consultants, Internal Audit Director -RN from the Corporate office, Director of Medical Review -RN from the corporate office) for residents with a BIMS score below 7 to ensure that no physical signs and symptoms of abuse were present. Results of body audits did not reflect any physical injuries. On 04/12/13 Department Managers (Dietary Manager, Staffing Coordinator) also met with license nurse and Certified Nurse Assistant (C.N.A.) (State Registered Nurse Aides) assigned to residents with a BIMS of seven (7) or less, thirty-six (36) residents, to interview for any noted change of behavior or any signs of fear. All above interviews were placed in a binder called the AOC binder located In the Administrator's office. Administrator #2, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assist
F 0226	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and a review of the facility's policy and procedures and investigations, it was determined the facility failed to have an effective system to ensure policy and procedures related to abuse were implemented for six of twenty-nine residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to ensure a suspicion of an incident of abuse was reported immediately, failed to ensure that a thorough investigation was conducted for an alleged incident of abuse involving a staff member, and failed to ensure residents were protected following a report of abuse and during the investigation process. Facility staff failed to ensure an allegation of abuse was reported timely. On 02/17/13, facility staff witnessed Licensed Practical Nurse (LPN) #1, the Charge Nurse, verbally abuse Resident #1 at approximately 7:35 AM. Staff attempted, between 11:30 AM and 12:00 PM, to contact the facility's Social Worker/Abuse Coordinator to report the allegation per the facility's policy. The Social Worker/Abuse Coordinator was unavailable and staff left a voice message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. After receipt of the report of alleged abuse, the facility failed to ensure residents were protected from potential further abuse. The facility's policies and procedures stated the Administrator and/or Director of Nursing (DON) and/or Social Worker were the staff that could make any immediate decisions related to the removal of the alleged abuser from direct care giving. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, the DON, and the Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. After completion of the facility's investigation, Administrator #1 reported as a result of the investigation, interviews, and a review of the witness statements, he could not come to a firm conclusion that abuse had occurred and the allegation of abuse was determined to be unsubstantiated by the facility. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223 and F225.) In addition, interview and record review revealed the facility failed to immediately initiate an investigation, failed to ensure residents were protected from further potential abuse during an investigation, and failed to notify the Administrator and appropriate State Agencies for allegations of potential abuse involving Residents #4, #19, #29, #30, and #31. (Refer to F225.) The facility's failure to have an effective system in place to ensure the development and implementation of policies and procedures to protect residents from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F226 - S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed, any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse.

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F 0226	(continued... from page 22) 1. A review of the facility's investigation revealed on 02/17/13, staff reported Resident #1 was crying, and wanted to be put to bed. However, based on documentation, staff reported LPN #1 (who was the Charge Nurse) would not allow staff to put the resident to bed due to the resident yelling and crying. The investigation further revealed the LPN was immediately suspended on 02/17/13 pending the outcome of the investigation. Further, during the investigation, other residents were interviewed, and one resident reported he/she had overheard LPN #1 say negative things about another resident at the facility. According to the investigation, dated 02/22/13, the facility did not substantiate that the abuse occurred. During the course of the investigation, attempts were made to contact LPN #1 for interview. However, LPN #1 was no longer employed by the facility and attempts to contact the LPN were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from employment by the facility on 02/25/13 for falsification of documentation. Interview with the Staff Development Coordinator/Unit Manager on 02/28/13 at 5:35 PM and again on 03/04/13 at 11:07 AM revealed she came to the facility on [DATE] at approximately 11:00 AM to do a weekend check. At approximately 11:30 AM-11:40 AM, Housekeepers #1 and #2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and Resident #1. The Staff Development Coordinator/Unit Manager stated the housekeepers informed her Resident #1 asked to be put to bed and the LPN refused to allow staff to put the resident to bed and that they had attempted to contact the Social Worker/Abuse Coordinator prior to notifying her in accordance with facility policy. The Staff Development Coordinator/Unit Manager stated after the housekeepers spoke with her she went out on the floor, started an investigation, talked to individuals on the unit, and had the staff fill out written statements. She stated she spoke with State Registered Nurse Aides and an Activities Worker and had them fill out witness statements. The Staff Development Coordinator/Unit Manager stated LPN #1 remained on the nursing unit at the nurses' station during the time she initiated the investigation. She stated she did not remove LPN #1 from the floor immediately because she was trying to determine if it was appropriate for her to pull the LPN from the floor. Between 11:30 AM and 12:30 PM she attempted to call the Social Worker/Abuse Coordinator, for further guidance, per the facility policy; however, she was unable to contact her via phone. According to the Staff Development Coordinator/Unit Manager, she then contacted the Facility's Nurse Consultant for further direction, and informed LPN #1 that she was being sent home pending the final investigation. She further stated she did not know if she could remove staff from the floor, and the allegation had to be justifiable to remove facility staff from the floor. Further interview revealed she was not sure what was being reported by the housekeepers was abuse. However, review of the facility's policy revealed any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. In addition, the policy stated the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. However, interview and record review revealed these procedures were not implemented. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM confirmed she had received a voice mail message from one of the facility housekeepers and the Staff Development Coordinator/Nurse Manager on 02/17/13. She stated she came to the facility the same day and assisted with the investigation. Further interview with the Social Worker/Abuse Coordinator on 03/04/13, at 1:25 PM, revealed staff had been trained to report allegations of abuse to her, the DON or the Administrator. The Social Worker/Abuse Coordinator further stated she was not sure if a nurse could remove a staff member from direct resident care in the event an allegation of abuse had been made and staff could not reach Administrative staff. Review of staff training records revealed the last abuse training provided by the facility was in December 2012. Interview with Administrator #1 on 02/28/13 at 5:20 PM, revealed LPN #1 did not have a history of abuse and staff may have misinterpreted the LPN since she was loud by nature. Administrator #1 stated they could not come to a firm conclusion related to abuse, at the conclusion of the investigation, and the facility was not able to substantiate that abuse occurred. Interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility policy instructed staff to seek guidance from him, the DON, or the Social Worker/Abuse Coordinator prior to the removal of the alleged perpetrator after an allegation of abuse was made. Per interview, he was not aware the facility's abuse policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, review of the facility's policy revealed only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Interview with the facility's Vice President of Operations, Chief Nurse Executive, and the Nurse Consultant on 03/04/13 at 5:05 PM, revealed the facility's abuse policy had been developed at the corporate level and they were not aware the policy indicated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact following an allegation of suspected abuse. 2. Interview with Resident #29 on 04/05/13 at 5:50 PM, revealed the resident reported he/she was afraid of SRNA #14 because he had touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated SRNA #14 was moved to another area in the facility to work after he/she reported the incident to the facility's Social Worker/Abuse Coordinator. Interview with the Social Worker/Abuse Coordinator on 04/05/13, at 3:30 PM, revealed she also acted as the facility's Abuse Coordinator, was responsible to assist with investigations related to abuse/neglect, and to provide staff education/in-service related to abuse/neglect as indicated. The Social Worker/Abuse Coordinator stated in accordance with facility policy allegations of alleged abuse were to be immediately investigated and reported to the appropriate state agencies. The Social Worker/Abuse Coordinator further stated she had received training from the facility regarding the facility's abuse policies/procedures when she was hired by the facility on 06/20/11, as well as when the policy, which included reporting, investigation, and resident protection of abuse allegations, was revised in March 2013. Further interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she and Administrator #1 talked with the resident about the incident and the resident stated he/she felt the touching incident was inappropriate. The Social Worker/Abuse Coordinator further stated Resident #29 told her he/she did not feel the incident was abuse. According to the Social Worker/Abuse Coordinator, SRNA #14 was moved to another unit in the facility following the report by Resident #29 and was allowed to continue to provide direct care for residents. Although the Social Worker/Abuse Coordinator stated she did obtain statements from Resident #29, the resident's daughter, SRNA #14, and a staff nurse assigned to the Seasons Unit, she did not further investigate the alleged incident. The Social Worker/Abuse Coordinator also stated since the resident stated she did not feel the incident was abuse, she did not report the alleged incident to the State Agencies. An additional interview conducted on 04/09/13, at 11:09 AM, with the Social Worker/Abuse Coordinator revealed she was no longer employed by the facility effective 04/08/13 due to illness. During this interview, the Social Worker/Abuse Coordinator stated she routinely reported all allegations to the DON or Administrator; and they would direct her on the procedures to follow when an allegation of abuse was reported, including investigation, protection, and reporting. The Social Worker/Abuse Coordinator stated she had missed doing some things during the investigation of the incident reported by Resident #29. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was currently acting as the facility's Administrator, and was not aware of the incident involving Resident #29. Further interview with the Vice President of Operations on 04/05/13 at 7:30 PM, revealed SRNA #14 continued to work at the facility in the provision of direct care after Resident #29 had reported the incident and was still providing direct resident care on 04/05/13. However, the Vice President of Operations stated SRNA #14 was suspended from employment after he was informed of the alleged incident on 04/05/13. The Vice President of Operations also confirmed no further investigation had been conducted by the facility of the alleged incident and he could provide no evidence the allegation had been reported to the state agencies as directed by the facility's abuse policy. 3. Review of the facility's investigation, initiated by the facility's Social Worker/Abuse Coordinator on 03/24/13, revealed Resident #30 reported on 03/24/13, that on 03/22/13, from 8:00 PM to 9:00 PM, SRNA #13 had sprayed cold water on the resident while in the shower and had wrapped a sheet too tight around the resident's neck. Continued review revealed the investigation was not completed and the allegation was not reported to the appropriate state agencies until 04/09/13, (sixteen days after the incident was reported). It could not be determined by a review of documentation if the facility had protected residents from further potential abuse while the investigation was being conducted, or if the facility allowed SRNA #13 to continue to provide resident care at the facility. According to the initial report, dated 04/09/13, the facility had attempted to contact SRNA #13 to inform the SRNA that she would be suspended and not allowed to work until the investigation had been completed. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation of the allegation had not

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F 0226	(continued... from page 23) been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was not aware the allegation of abuse had not been thoroughly investigated and reported as required until the Social Worker/Abuse Coordinator had reported on 04/08/13 that the investigation was not complete. At the time of the interview, Administrator #2 could provide no documentation that any action had taken to ensure residents were protected during the facility's investigation or that the allegation had been reported to the appropriate State Agencies. According to Administrator #2, the allegations were logged in an abuse investigation log at the end of each day. However, review of the facility's investigation log revealed no entry regarding Resident #30. 4. A review of the facility's investigation dated 04/01/13 revealed on 03/27/13, the Administrator was informed that Resident #4 had made an allegation of abuse on 03/24/13, three days prior. According to the investigation, Resident #4 was interviewed on 03/28/13 and reported that no one had been mean to (her/him). When the facility questioned the resident if he/she had alleged someone was mean to him/her the resident stated he/she had told one of the women that. According to the facility's investigation, the resident didn't really mean it. The Social Worker/Abuse Coordinator asked the resident if the woman was RN #8 and the resident stated, Yeah my little nurse. Further review of the investigation revealed RN #8 stated Resident #4 did make the statement on 03/24/13 that she was mean to the resident. RN #8 reported she had told the resident to use the call light for assistance instead of getting up on her own. All residents assessed by the facility to be interviewable were interviewed in regards to their treatment. The investigation concluded the allegation of abuse was unsubstantiated based on Resident #4's moderately impaired cognitive ability. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on the morning of 03/24/13 Resident #4 alleged the RN was mean to the resident and Resident #4 did not want RN #8 to come into the resident's room again or provide care for the resident. RN #8 stated she documented the incident in the nurse's notes, and only thought Resident #4 was upset the morning of 03/24/13. However, RN #8 stated she should have told another nurse; removed herself from the floor; and called the Administrator and DON. RN #8 stated the incident didn't seem like an allegation of abuse. Interview with the DON on 04/02/13 at 8:45 PM revealed she was informed of the allegation against RN #8 on 03/24/13 by the Weekend Manager. She stated she did not give the Weekend Manager any further instructions. The DON stated on 03/25/13 she interviewed Resident #4; got side tracked with something else; and did not notify the Administrator or interview RN #8. The DON stated on 03/27/13, the Corporate Nurse Consultant questioned her related to a nurse's note found in Resident #4's medical record related to the incident. The DON stated she called RN #8 and had her come in to work early on the evening of 03/27/13 to obtain an interview. After interviewing the nurse, the DON and Administrator #2 allowed RN #8 to work her scheduled 12-hour shift. The DON stated since RN #8 and Resident #4 denied the allegation, she and Administrator #2 decided abuse did not occur. However, the DON acknowledged the facility's investigation had not been finished at the time of the interview. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM revealed he became aware of the incident on 03/27/13, at approximately 5:40 PM, and spoke to the DON regarding the incident. Administrator #2 stated the DON informed him she had forgotten to inform him of the allegation of abuse and failed to initiate an investigation related to the allegation. Further, Administrator #2 stated he sat in during the interview between the DON and RN #8; however, he was half paying attention. Administrator #2 initially stated in interview that he was not aware RN #8 had been permitted to work on 03/27/13 and that he didn't ask (DON) why she didn't remove the alleged perpetrator. Continued interview with Administrator #2 revealed he was aware RN #8 had been permitted to work after the interview had been conducted on 03/27/13 while the investigation was in progress. Interview further revealed Administrator #2 did not think it was reportable and stated, In my heart of hearts I have gotten to know the little girl while I've been here, I just didn't feel it was true and reportable. Further interview revealed Administrator #2 had not interviewed the DON regarding the incident and stated the DON had just forgotten to do anything with the information she received on 03/24/13. Administrator #2 stated RN #8 should have reported the incident to another Charge Nurse on 03/24/13; that he should have been notified of the incident; and, that RN #8 should have been sent home on 03/24/13 following the incident. Continued interview with Administrator #2 on 03/29/13 at 4:11 PM revealed he did concur with the DON on 03/27/13 related to allowing RN #8 to work her shift after the resident stated he/she did not want RN #8 to take care of her. Per interview, he and the DON agreed RN #8 could continue to provide resident care. Administrator #2 further stated in hindsight with the facility the way it is right now allowing the RN to continue to work during the investigation was probably a bad decision. 5. Review of the facility's investigation revealed SRNA #1 and SRNA #8 reported to the facility's Social Worker/Abuse Coordinator that on 04/04/13, they overheard a Lab Technician tell Resident #19 It's going to hurt you worse than it will me because I have a needle stuck in your arm. Even though the investigation revealed the incident had been reported immediately to the facility's Social Worker/Abuse Coordinator on 04/04/13, the facility failed to ensure the allegation was immediately reported to the required state agencies until 04/06/13 (two days after the incident was reported). Interview on 04/09/13 at 2:55 PM with the Corporate Nurse Executive who had completed the investigation of the allegation revealed she initially had not considered the allegation reportable. However, the Corporate Nurse Executive stated as a part of the facility's ongoing audits, the allegation was determined to be an allegation of verbal abuse and was reported to the appropriate State Agencies late, on 04/06/13. The Corporate Nurse Executive stated the allegation being reported late was better than not reporting the allegation. 6. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13 of an abuse allegation involving Resident #31 but she could not recall the date of the allegation. An interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 could not recall the allegation regarding Resident #31 that was reported on 04/08/13 and an investigation of the allegation had not been initiated. Continued interview with Administrator #2 on 04/09/13 at 5:00 PM revealed Administrator #2 had discussed the allegation reported by the Social Worker/Abuse Coordinator on 04/08/13 with staff and learned there was an allegation that Resident #31 may have been sat down in a chair too hard by facility staff around 3/17-19/13, but no witness statements or investigation could be found. Review of the facility's investigation log revealed no entry regarding the alleged incident involving Resident #31, which was reported on 04/08/13. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: The allegation of abuse against Resident #31 was reported to appropriate State Agencies on 04/09/13 by Administrator #2. The Interim Social Services Director (SSD) completed an interview with Resident #31 and the resident's daughter on 04/09/13. The facility suspended the alleged perpetrator on 04/09/13. Other employees were interviewed by the Vice President of Human Resources and the Regional Human Resources Director on 04/10/13 to identify if any other staff had observed the alleged perpetrator be rude or rough with any other residents. All residents with a BIMS score of seven or above were interviewed by Regional Staff regarding any concerns with rough or rude treatment and no concerns were identified. The allegation of abuse against Resident #19 was reported to the appropriate State Agencies by the Chief Nurse Executive on 04/06/13. A body audit on Resident #19 was completed by the Regional Nurse Consultant on 04/04/13. Statements were obtained from the lab technician, the alleged perpetrator, on 04/08/13. Statements were obtained on 04/04/13 from two staff members who were present during the alleged abuse. The supervisor of the lab technician was notified by the Chief Nurse Executive on 04/04/13 that the facility would no longer utilize the lab technician. The allegation of abuse against Resident #30 was reported to the appropriate State Agencies on 04/09/13 by Administrator #2. The Administrator and the Interim Social Services Director interviewed Resident #30 on 04/10/13 regarding the alleged abuse incident. Statements were obtained on 04/10/13 from the two staff who was the alleged perpetrators. The two alleged perpetrators were suspended on 04/10/13. An interview was completed by the Chief Operating Officer on 04/09/13 with the Nurse who provided care for Resident #30 on the evening of the alleged incident. Interviews were completed by Regional Staff on 04/09/13 with other residents who reside on the same unit as Resident #30, regarding staff treatment during care, with no concerns identified. The allegation of abuse against Resident #29 was reported to the appropriate State Agencies on 04/05/13 by the Chief Nurse Executive. Administrator #2 and the Interim Social Services Director interviewed Resident #29 on 04/05/13 regarding the alleged abuse. The Regional Nurse completed a body audit on Resident #29 on 04/05/13 with no injuries identified. The alleged perpetrator was interviewed by the Vice President of Human Resources and the Chief Operating Officer along with a statement obtained. The alleged perpetrator was suspended on 04/05/13 along with Administrator #1, who was the facility ' s Administrator at the time of the occurrence, Resident ' s with a BIMS score over 7 was interviewed by Department Managers on 04/05/13 and Regional Staff on 04/05/13 regarding other incidents of inappropriate treatments, with no concerns identified. The allegation of abuse by Resident #4 was reported to the appropriate State Agencies on 03/30/13 by Administrator #2 and a final report was submitted on 04/03/13 to the appropriate State Agencies, which unsubstantiated abuse regarding Resident #4. The second allegation of abuse by Resident #4 was submitted to the appropriate State Agencies on 04/09/13. The staff member who was the alleged abuser was suspended during the investigation. A third allegation by Resident #4 was submitted

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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on 04/09/13 regarding a review of an incident report dated 03/28/13 for bruises. The investigation was in progress. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a posttest. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed, will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Independent Contractor initiated continued abuse education regarding identifying, reporting, and ensuring resident safety on 04/11/13. All staff scheduled to work will receive this re-education by 04/12/13. Staff not scheduled to work during that time frame, who work as needed, or who are on leave of absence will receive the education upon returning to work, by Administrator #2, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Staff Development Coordinator, or Regional Staff. On 04/12/13 thirty-four (34) interviews were conducted by the Department Managers (Staffing Coordinator, Dietary Manager, Housekeeping Director) for residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or above to determine their feelings of safety and identify any allegations of mistreatment or abuse. There were no concerns voiced. A body audit was complete for eighty-one (81) residents, there were an additional nine (9) residents who refused a body audit therefore the audit was not performed on those nine (9), by Administrative Nurses (MDS Coordinators, DON, Staff Development Coordinator), on 04/12/13 and regional nurses (Signature Care Consultants, Internal Audit Director -RN from the Corporate office, Director of Medical Review -RN from the corporate office) for residents with a BIMS score below 7 to ensure that no physical signs and symptoms of abuse were present. Results of body audits did not reflect any physical injuries. On 04/12/13 Department Managers (Dietary Manager, Staffing Coordinator) also met with license nurse and Certified Nurse Assistant (C.N.A.) (State Registered Nurse Aides) assigned to residents with a BIMS of seven (7) or less, thirty-six (36) residents, to interview for any noted change of behavior or any signs of fear. All above interviews were placed in a binder called the AOC binder located In the Administrator's office. Administrator #2, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assist

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Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, and a review of the facility's policy and procedures and investigations, it was determined the facility failed to have an effective system to ensure policy and procedures related to abuse were implemented for six of twenty-nine residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to ensure a suspicion of an incident of abuse was reported immediately, failed to ensure that a thorough investigation was conducted for an alleged incident of abuse involving a staff member, and failed to ensure residents were protected following a report of abuse and during the investigation process. Facility staff failed to ensure an allegation of abuse was reported timely. On 02/17/13, facility staff witnessed Licensed Practical Nurse (LPN) #1, the Charge Nurse, verbally abuse Resident #1 at approximately 7:35 AM. Staff attempted, between 11:30 AM and 12:00 PM, to contact the facility's Social Worker/Abuse Coordinator to report the allegation per the facility's policy. The Social Worker/Abuse Coordinator was unavailable and staff left a voice message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. After receipt of the report of alleged abuse, the facility failed to ensure residents were protected from potential further abuse. The facility's policies and procedures stated the Administrator and/or Director of Nursing (DON) and/or Social Worker were the staff that could make any immediate decisions related to the removal of the alleged abuser from direct care giving. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, the DON, and the Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. After completion of the facility's investigation, Administrator #1 reported as a result of the investigation, interviews, and a review of the witness statements, he could not come to a firm conclusion that abuse had occurred and the allegation of abuse was determined to be unsubstantiated by the facility. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223 and F225.) In addition, interview and record review revealed the facility failed to immediately initiate an investigation, failed to ensure residents were protected from further potential abuse during an investigation, and failed to notify the Administrator and appropriate State Agencies for allegations of potential abuse involving Residents #4, #19, #29, #30, and #31. (Refer to F225.) The facility's failure to have an effective system in place to ensure the development and implementation of policies and procedures to protect residents from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F226 - S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed, any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse.
1. A review of the facility's investigation revealed on 02/17/13, staff reported Resident #1 was crying, and wanted to be put to bed. However, based on documentation, staff reported LPN #1 (who was the Charge Nurse) would not allow staff to put the resident to bed due to the resident yelling and crying. The investigation further revealed the LPN was immediately suspended on 02/17/13 pending the outcome of the investigation. Further, during the investigation, other residents were interviewed, and one resident reported he/she had overheard LPN #1 say negative things about another resident at the

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facility. According to the investigation, dated 02/22/13, the facility did not substantiate that the abuse occurred. During the course of the investigation, attempts were made to contact LPN #1 for interview. However, LPN #1 was no longer employed by the facility and attempts to contact the LPN were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from employment by the facility on 02/25/13 for falsification of documentation. Interview with the Staff Development Coordinator/Unit Manager on 02/28/13 at 5:35 PM and again on 03/04/13 at 11:07 AM revealed she came to the facility on [DATE] at approximately 11:00 AM to do a weekend check. At approximately 11:30 AM-11:40 AM, Housekeepers #1 and
#2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and Resident #1. The Staff Development Coordinator/Unit Manager stated the housekeepers informed her Resident #1 asked to be put to bed and the LPN refused to allow staff to put the resident to bed and that they had attempted to contact the Social Worker/Abuse Coordinator prior to notifying her in accordance with facility policy. The Staff Development Coordinator/Unit Manager stated after the housekeepers spoke with her she went out on the floor, started an investigation, talked to individuals on the unit, and had the staff fill out written statements. She stated she spoke with State Registered Nurse Aides and an Activities Worker and had them fill out witness statements. The Staff Development Coordinator/Unit Manager stated LPN #1 remained on the nursing unit at the nurses' station during the time she initiated the investigation. She stated she did not remove LPN #1 from the floor immediately because she was trying to determine if it was appropriate for her to pull the LPN from the floor. Between 11:30 AM and 12:30 PM she attempted to call the Social Worker/Abuse Coordinator, for further guidance, per the facility policy; however, she was unable to contact her via phone. According to the Staff Development Coordinator/Unit Manager, she then contacted the Facility's Nurse Consultant for further direction, and informed LPN #1 that she was being sent home pending the final investigation. She further stated she did not know if she could remove staff from the floor, and the allegation had to be justifiable to remove facility staff from the floor. Further interview revealed she was not sure what was being reported by the housekeepers was abuse. However, review of the facility's policy revealed any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. In addition, the policy stated the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. However, interview and record review revealed these procedures were not implemented. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM confirmed she had received a voice mail message from one of the facility housekeepers and the Staff Development Coordinator/Nurse Manager on 02/17/13. She stated she came to the facility the same day and assisted with the investigation. Further interview with the Social Worker/Abuse Coordinator on 03/04/13, at 1:25 PM, revealed staff had been trained to report allegations of abuse to her, the DON or the Administrator. The Social Worker/Abuse Coordinator further stated she was not sure if a nurse could remove a staff member from direct resident care in the event an allegation of abuse had been made and staff could not reach Administrative staff. Review of staff training records revealed the last abuse training provided by the facility was in December 2012. Interview with Administrator #1 on 02/28/13 at 5:20 PM, revealed LPN #1 did not have a history of abuse and staff may have misinterpreted the LPN since she was loud by nature. Administrator #1 stated they could not come to a firm conclusion related to abuse, at the conclusion of the investigation, and the facility was not able to substantiate that abuse occurred. Interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility policy instructed staff to seek guidance from him, the DON, or the Social Worker/Abuse Coordinator prior to the removal of the alleged perpetrator after an allegation of abuse was made. Per interview, he was not aware the facility's abuse policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, review of the facility's policy revealed only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Interview with the facility's Vice President of Operations, Chief Nurse Executive, and the Nurse Consultant on 03/04/13 at 5:05 PM, revealed the facility's abuse policy had been developed at the corporate level and they were not aware the policy indicated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact following an allegation of suspected abuse. 2. Interview with Resident #29 on 04/05/13 at 5:50 PM, revealed the resident reported he/she was afraid of SRNA #14 because he had touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated SRNA #14 was moved to another area in the facility to work after he/she reported the incident to the facility's Social Worker/Abuse Coordinator. Interview with the Social Worker/Abuse Coordinator on 04/05/13, at 3:30 PM, revealed she also acted as the facility's Abuse Coordinator, was responsible to assist with investigations related to abuse/neglect, and to provide staff education/in-service related to abuse/neglect as indicated. The Social Worker/Abuse Coordinator stated in accordance with facility policy allegations of alleged abuse were to be immediately investigated and reported to the appropriate state agencies. The Social Worker/Abuse Coordinator further stated she had received training from the facility regarding the facility's abuse policies/procedures when she was hired by the facility on 06/20/11, as well as when the policy, which included reporting, investigation, and resident protection of abuse allegations, was revised in March 2013. Further interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she and Administrator #1 talked with the resident about the incident and the resident stated he/she felt the touching incident was inappropriate. The Social Worker/Abuse Coordinator further stated Resident #29 told her he/she did not feel the incident was abuse. According to the Social Worker/Abuse Coordinator, SRNA #14 was moved to another unit in the facility following the report by Resident #29 and was allowed to continue to provide direct care for residents. Although the Social Worker/Abuse Coordinator stated she did obtain statements from Resident #29, the resident's daughter, SRNA #14, and a staff nurse assigned to the Seasons Unit, she did not further investigate the alleged incident. The Social Worker/Abuse Coordinator also stated since the resident stated she did not feel the incident was abuse, she did not report the alleged incident to the State Agencies. An additional interview conducted on 04/09/13, at 11:09 AM, with the Social Worker/Abuse Coordinator revealed she was no longer employed by the facility effective 04/08/13 due to illness. During this interview, the Social Worker/Abuse Coordinator stated she routinely reported all allegations to the DON or Administrator; and they would direct her on the procedures to follow when an allegation of abuse was reported, including investigation, protection, and reporting. The Social Worker/Abuse Coordinator stated she had missed doing some things during the investigation of the incident reported by Resident #29. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was currently acting as the facility's Administrator, and was not aware of the incident involving Resident #29. Further interview with the Vice President of Operations on 04/05/13 at 7:30 PM, revealed SRNA #14 continued to work at the facility in the provision of direct care after Resident #29 had reported the incident and was still providing direct resident care on 04/05/13. However, the Vice President of Operations stated SRNA #14 was suspended from employment after he was informed of the alleged incident on 04/05/13. The Vice President of Operations also confirmed no further investigation had been conducted by the facility of the alleged incident and he could provide no evidence the allegation had been reported to the state agencies as directed by the facility's abuse policy. 3. Review of the facility's investigation, initiated by the facility's Social Worker/Abuse Coordinator on 03/24/13, revealed Resident #30 reported on 03/24/13, that on 03/22/13, from 8:00 PM to 9:00 PM, SRNA #13 had sprayed cold water on the resident while in the shower and had wrapped a sheet too tight around the resident's neck. Continued review revealed the investigation was not completed and the allegation was not reported to the appropriate state agencies until 04/09/13, (sixteen days after the incident was reported). It could not be determined by a review of documentation if the facility had protected residents from further potential abuse while the investigation was being conducted, or if the facility allowed SRNA #13 to continue to provide resident care at the facility. According to the initial report, dated 04/09/13, the facility had attempted to contact SRNA #13 to inform the SRNA that she would be suspended and not allowed to work until the investigation had been completed. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation of the allegation had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was not aware the allegation of abuse had not been thoroughly investigated and reported as required until the Social Worker/Abuse Coordinator had reported on 04/08/13 that the investigation was not complete. At the time of the interview, Administrator #2 could provide no documentation that any action had taken to ensure residents were protected during the facility's investigation or that the allegation had been reported to the appropriate State Agencies. According to Administrator #2, the allegations

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were logged in an abuse investigation log at the end of each day. However, review of the facility's investigation log revealed no entry regarding Resident #30. 4. A review of the facility's investigation dated 04/01/13 revealed on 03/27/13, the Administrator was informed that Resident #4 had made an allegation of abuse on 03/24/13, three days prior. According to the investigation, Resident #4 was interviewed on 03/28/13 and reported that no one had been mean to (her/him). When the facility questioned the resident if he/she had alleged someone was mean to him/her the resident stated he/she had told one of the women that. According to the facility's investigation, the resident didn't really mean it. The Social Worker/Abuse Coordinator asked the resident if the woman was RN #8 and the resident stated, Yeah my little nurse. Further review of the investigation revealed RN #8 stated Resident #4 did make the statement on 03/24/13 that she was mean to the resident. RN #8 reported she had told the resident to use the call light for assistance instead of getting up on her own. All residents assessed by the facility to be interviewable were interviewed in regards to their treatment. The investigation concluded the allegation of abuse was unsubstantiated based on Resident #4's moderately impaired cognitive ability. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on the morning of 03/24/13 Resident #4 alleged the RN was mean to the resident and Resident #4 did not want RN #8 to come into the resident's room again or provide care for the resident. RN #8 stated she documented the incident in the nurse's notes, and only thought Resident #4 was upset the morning of 03/24/13. However, RN #8 stated she should have told another nurse; removed herself from the floor; and called the Administrator and DON. RN #8 stated the incident didn't seem like an allegation of abuse. Interview with the DON on 04/02/13 at 8:45 PM revealed she was informed of the allegation against RN #8 on 03/24/13 by the Weekend Manager. She stated she did not give the Weekend Manager any further instructions. The DON stated on 03/25/13 she interviewed Resident #4; got side tracked with something else; and did not notify the Administrator or interview RN #8. The DON stated on 03/27/13, the Corporate Nurse Consultant questioned her related to a nurse's note found in Resident #4's medical record related to the incident. The DON stated she called RN #8 and had her come in to work early on the evening of 03/27/13 to obtain an interview. After interviewing the nurse, the DON and Administrator #2 allowed RN #8 to work her scheduled 12-hour shift. The DON stated since RN #8 and Resident #4 denied the allegation, she and Administrator #2 decided abuse did not occur. However, the DON acknowledged the facility's investigation had not been finished at the time of the interview. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM revealed he became aware of the incident on 03/27/13, at approximately 5:40 PM, and spoke to the DON regarding the incident. Administrator #2 stated the DON informed him she had forgotten to inform him of the allegation of abuse and failed to initiate an investigation related to the allegation.
Further, Administrator #2 stated he sat in during the interview between the DON and RN #8; however, he was half paying attention. Administrator #2 initially stated in interview that he was not aware RN #8 had been permitted to work on 03/27/13 and that he didn't ask (DON) why she didn't remove the alleged perpetrator. Continued interview with Administrator #2 revealed he was aware RN #8 had been permitted to work after the interview had been conducted on 03/27/13 while the investigation was in progress. Interview further revealed Administrator #2 did not think it was reportable and stated, In my heart of hearts I have gotten to know the little girl while I've been here, I just didn't feel it was true and reportable. Further interview revealed Administrator #2 had not interviewed the DON regarding the incident and stated the DON had just forgotten to do anything with the information she received on 03/24/13. Administrator #2 stated RN #8 should have reported the incident to another Charge Nurse on 03/24/13; that he should have been notified of the incident; and, that RN #8 should have been sent home on 03/24/13 following the incident. Continued interview with Administrator #2 on 03/29/13 at 4:11 PM revealed he did concur with the DON on 03/27/13 related to allowing RN #8 to work her shift after the resident stated he/she did not want RN #8 to take care of her. Per interview, he and the DON agreed RN #8 could continue to provide resident care. Administrator #2 further stated in hindsight with the facility the way it is right now allowing the RN to continue to work during the investigation was probably a bad decision. 5. Review of the facility's investigation revealed SRNA #1 and SRNA #8 reported to the facility's Social Worker/Abuse Coordinator that on 04/04/13, they overheard a Lab Technician tell Resident #19 It's going to hurt you worse than it will me because I have a needle stuck in your arm. Even though the investigation revealed the incident had been reported immediately to the facility's Social Worker/Abuse Coordinator on 04/04/13, the facility failed to ensure the allegation was immediately reported to the required state agencies until 04/06/13 (two days after the incident was reported). Interview on 04/09/13 at 2:55 PM with the Corporate Nurse Executive who had completed the investigation of the allegation revealed she initially had not considered the allegation reportable. However, the Corporate Nurse Executive stated as a part of the facility's ongoing audits, the allegation was determined to be an allegation of verbal abuse and was reported to the appropriate State Agencies late, on 04/06/13. The Corporate Nurse Executive stated the allegation being reported late was better than not reporting the allegation. 6. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13 of an abuse allegation involving Resident #31 but she could not recall the date of the allegation. An interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 could not recall the allegation regarding Resident #31 that was reported on 04/08/13 and an investigation of the allegation had not been initiated. Continued interview with Administrator #2 on 04/09/13 at 5:00 PM revealed Administrator #2 had discussed the allegation reported by the Social Worker/Abuse Coordinator on 04/08/13 with staff and learned there was an allegation that Resident #31 may have been sat down in a chair too hard by facility staff around 3/17-19/13, but no witness statements or investigation could be found. Review of the facility's investigation log revealed no entry regarding the alleged incident involving Resident #31, which was reported on 04/08/13. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: The allegation of abuse against Resident #31 was reported to appropriate State Agencies on 04/09/13 by Administrator #2. The Interim Social Services Director (SSD) completed an interview with Resident #31 and the resident's daughter on 04/09/13. The facility suspended the alleged perpetrator on 04/09/13. Other employees were interviewed by the Vice President of Human Resources and the Regional Human Resources Director on 04/10/13 to identify if any other staff had observed the alleged perpetrator be rude or rough with any other residents. All residents with a BIMS score of seven or above were interviewed by Regional Staff regarding any concerns with rough or rude treatment and no concerns were identified. The allegation of abuse against Resident #19 was reported to the appropriate State Agencies by the Chief Nurse Executive on 04/06/13. A body audit on Resident #19 was completed by the Regional Nurse Consultant on 04/04/13. Statements were obtained from the lab technician, the alleged perpetrator, on 04/08/13. Statements were obtained on 04/04/13 from two staff members who were present during the alleged abuse. The supervisor of the lab technician was notified by the Chief Nurse Executive on 04/04/13 that the facility would no longer utilize the lab technician. The allegation of abuse against Resident #30 was reported to the appropriate State Agencies on 04/09/13 by Administrator #2. The Administrator and the Interim Social Services Director interviewed Resident #30 on 04/10/13 regarding the alleged abuse incident. Statements were obtained on 04/10/13 from the two staff who was the alleged perpetrators. The two alleged perpetrators were suspended on 04/10/13. An interview was completed by the Chief Operating Officer on 04/09/13 with the Nurse who provided care for Resident #30 on the evening of the alleged incident. Interviews were completed by Regional Staff on 04/09/13 with other residents who reside on the same unit as Resident #30, regarding staff treatment during care, with no concerns identified. The allegation of abuse against Resident #29 was reported to the appropriate State Agencies on 04/05/13 by the Chief Nurse Executive. Administrator #2 and the Interim Social Services Director interviewed Resident #29 on 04/05/13 regarding the alleged abuse. The Regional Nurse completed a body audit on Resident #29 on 04/05/13 with no injuries identified. The alleged perpetrator was interviewed by the Vice President of Human Resources and the Chief Operating Officer along with a statement obtained. The alleged perpetrator was suspended on 04/05/13 along with Administrator #1, who was the facility ' s Administrator at the time of the occurrence, Resident ' s with a BIMS score over 7 was interviewed by Department Managers on 04/05/13 and Regional Staff on 04/05/13 regarding other incidents of inappropriate treatments, with no concerns identified. The allegation of abuse by Resident #4 was reported to the appropriate State Agencies on 03/30/13 by Administrator #2 and a final report was submitted on 04/03/13 to the appropriate State Agencies, which unsubstantiated abuse regarding Resident #4. The second allegation of abuse by Resident #4 was submitted to the appropriate State Agencies on 04/09/13. The staff member who was the alleged abuser was suspended during the investigation. A third allegation by Resident #4 was submitted on 04/09/13 regarding a review of an incident report dated 03/28/13 for bruises. The investigation was in progress. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a posttest. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed, will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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(continued... from page 27)
oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Independent Contractor initiated continued abuse education regarding identifying, reporting, and ensuring resident safety on 04/11/13. All staff scheduled to work will receive this re-education by 04/12/13. Staff not scheduled to work during that time frame, who work as needed, or who are on leave of absence will receive the education upon returning to work, by Administrator #2, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Staff Development Coordinator, or Regional Staff. On 04/12/13 thirty-four (34) interviews were conducted by the Department Managers (Staffing Coordinator, Dietary Manager, Housekeeping Director) for residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or above to determine their feelings of safety and identify any allegations of mistreatment or abuse. There were no concerns voiced. A body audit was complete for eighty-one (81) residents, there were an additional nine (9) residents who refused a body audit therefore the audit was not performed on those nine (9), by Administrative Nurses (MDS Coordinators, DON, Staff Development Coordinator), on 04/12/13 and regional nurses (Signature Care Consultants, Internal Audit Director -RN from the Corporate office, Director of Medical Review -RN from the corporate office) for residents with a BIMS score below 7 to ensure that no physical signs and symptoms of abuse were present. Results of body audits did not reflect any physical injuries. On 04/12/13 Department Managers (Dietary Manager, Staffing Coordinator) also met with license nurse and Certified Nurse Assistant (C.N.A.) (State Registered Nurse Aides) assigned to residents with a BIMS of seven (7) or less, thirty-six (36) residents, to interview for any noted change of behavior or any signs of fear. All above interviews were placed in a binder called the AOC binder located In the Administrator's office. Administrator #2, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assist

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Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, record review, and a review of the facility's policy and procedures and investigations, it was determined the facility failed to have an effective system to ensure policy and procedures related to abuse were implemented for six of twenty-nine residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to ensure a suspicion of an incident of abuse was reported immediately, failed to ensure that a thorough investigation was conducted for an alleged incident of abuse involving a staff member, and failed to ensure residents were protected following a report of abuse and during the investigation process. Facility staff failed to ensure an allegation of abuse was reported timely. On 02/17/13, facility staff witnessed Licensed Practical Nurse (LPN) #1, the Charge Nurse, verbally abuse Resident #1 at approximately 7:35 AM. Staff attempted, between 11:30 AM and 12:00 PM, to contact the facility's Social Worker/Abuse Coordinator to report the allegation per the facility's policy. The Social Worker/Abuse Coordinator was unavailable and staff left a voice message on the Social Worker/Abuse Coordinator's telephone. Staff reported the allegation of abuse to the Staff Development Coordinator/Nurse Manager on 02/17/13, at approximately 11:40 AM, approximately four hours after staff observed the abuse. After receipt of the report of alleged abuse, the facility failed to ensure residents were protected from potential further abuse. The facility's policies and procedures stated the Administrator and/or Director of Nursing (DON) and/or Social Worker were the staff that could make any immediate decisions related to the removal of the alleged abuser from direct care giving. Interviews revealed LPN #1 continued to be in charge of resident care and remained on the floor with residents during the time the Staff Development Coordinator/Nurse Manager initiated the investigation, talked with the other staff, and attempted to get direction from the Social Worker/Abuse Coordinator, the DON, and the Nurse Consultant on what action to take. LPN #1 remained in direct resident care until 12:30 PM, approximately five hours after staff observed the abuse. After completion of the facility's investigation, Administrator #1 reported as a result of the investigation, interviews, and a review of the witness statements, he could not come to a firm conclusion that abuse had occurred and the allegation of abuse was determined to be unsubstantiated by the facility. However, interview and record review revealed LPN #1 did not return to the facility and was terminated from the facility on 02/25/13 related to falsification of documentation. (Refer to F223 and F225.) In addition, interview and record review revealed the facility failed to immediately initiate an investigation, failed to ensure residents were protected from further potential abuse during an investigation, and failed to notify the Administrator and appropriate State Agencies for allegations of potential abuse involving Residents #4, #19, #29, #30, and #31. (Refer to F225.) The facility's failure to have an effective system in place to ensure the development and implementation of policies and procedures to protect residents from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices F226 - S/S E, while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed, any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse.
1. A review of the facility's investigation revealed on 02/17/13, staff reported Resident #1 was crying, and wanted to be put to bed. However, based on documentation, staff reported LPN #1 (who was the Charge Nurse) would not allow staff to put the resident to bed due to the resident yelling and crying. The investigation further revealed the LPN was immediately suspended on 02/17/13 pending the outcome of the investigation. Further, during the investigation, other residents were interviewed, and one resident reported he/she had overheard LPN #1 say negative things about another resident at the facility. According to the investigation, dated 02/22/13, the facility did not substantiate that the abuse occurred. During the course of the investigation, attempts were made to contact LPN #1 for interview. However, LPN #1 was no longer employed by the facility and attempts to contact the LPN were unsuccessful. A review of LPN #1's employee file revealed the LPN was terminated from employment by the facility on 02/25/13 for falsification of documentation. Interview with the Staff Development Coordinator/Unit Manager on 02/28/13 at 5:35 PM and again on 03/04/13 at 11:07 AM revealed she came to the

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F 0226	(continued... from page 28) facility on [DATE] at approximately 11:00 AM to do a weekend check. At approximately 11:30 AM-11:40 AM, Housekeepers #1 and #2 came to her and stated they felt a little uneasy and uncomfortable with what they had witnessed between LPN #1 and Resident #1. The Staff Development Coordinator/Unit Manager stated the housekeepers informed her Resident #1 asked to be put to bed and the LPN refused to allow staff to put the resident to bed and that they had attempted to contact the Social Worker/Abuse Coordinator prior to notifying her in accordance with facility policy. The Staff Development Coordinator/Unit Manager stated after the housekeepers spoke with her she went out on the floor, started an investigation, talked to individuals on the unit, and had the staff fill out written statements. She stated she spoke with State Registered Nurse Aides and an Activities Worker and had them fill out witness statements. The Staff Development Coordinator/Unit Manager stated LPN #1 remained on the nursing unit at the nurses' station during the time she initiated the investigation. She stated she did not remove LPN #1 from the floor immediately because she was trying to determine if it was appropriate for her to pull the LPN from the floor. Between 11:30 AM and 12:30 PM she attempted to call the Social Worker/Abuse Coordinator, for further guidance, per the facility policy; however, she was unable to contact her via phone. According to the Staff Development Coordinator/Unit Manager, she then contacted the Facility's Nurse Consultant for further direction, and informed LPN #1 that she was being sent home pending the final investigation. She further stated she did not know if she could remove staff from the floor, and the allegation had to be justifiable to remove facility staff from the floor. Further interview revealed she was not sure what was being reported by the housekeepers was abuse. However, review of the facility's policy revealed any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing, and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. In addition, the policy stated the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. However, interview and record review revealed these procedures were not implemented. Interview with the Social Worker/Abuse Coordinator on 02/28/13 at 4:53 PM confirmed she had received a voice mail message from one of the facility housekeepers and the Staff Development Coordinator/Nurse Manager on 02/17/13. She stated she came to the facility the same day and assisted with the investigation. Further interview with the Social Worker/Abuse Coordinator on 03/04/13, at 1:25 PM, revealed staff had been trained to report allegations of abuse to her, the DON or the Administrator. The Social Worker/Abuse Coordinator further stated she was not sure if a nurse could remove a staff member from direct resident care in the event an allegation of abuse had been made and staff could not reach Administrative staff. Review of staff training records revealed the last abuse training provided by the facility was in December 2012. Interview with Administrator #1 on 02/28/13 at 5:20 PM, revealed LPN #1 did not have a history of abuse and staff may have misinterpreted the LPN since she was loud by nature. Administrator #1 stated they could not come to a firm conclusion related to abuse, at the conclusion of the investigation, and the facility was not able to substantiate that abuse occurred. Interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility policy instructed staff to seek guidance from him, the DON, or the Social Worker/Abuse Coordinator prior to the removal of the alleged perpetrator after an allegation of abuse was made. Per interview, he was not aware the facility's abuse policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, review of the facility's policy revealed only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. Interview with the facility's Vice President of Operations, Chief Nurse Executive, and the Nurse Consultant on 03/04/13 at 5:05 PM, revealed the facility's abuse policy had been developed at the corporate level and they were not aware the policy indicated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact following an allegation of suspected abuse. 2. Interview with Resident #29 on 04/05/13 at 5:50 PM, revealed the resident reported he/she was afraid of SRNA #14 because he had touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated SRNA #14 was moved to another area in the facility to work after he/she reported the incident to the facility's Social Worker/Abuse Coordinator. Interview with the Social Worker/Abuse Coordinator on 04/05/13, at 3:30 PM, revealed she also acted as the facility's Abuse Coordinator, was responsible to assist with investigations related to abuse/neglect, and to provide staff education/in-service related to abuse/neglect as indicated. The Social Worker/Abuse Coordinator stated in accordance with facility policy allegations of alleged abuse were to be immediately investigated and reported to the appropriate state agencies. The Social Worker/Abuse Coordinator further stated she had received training from the facility regarding the facility's abuse policies/procedures when she was hired by the facility on 06/20/11, as well as when the policy, which included reporting, investigation, and resident protection of abuse allegations, was revised in March 2013. Further interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she and Administrator #1 talked with the resident about the incident and the resident stated he/she felt the touching incident was inappropriate. The Social Worker/Abuse Coordinator further stated Resident #29 told her he/she did not feel the incident was abuse. According to the Social Worker/Abuse Coordinator, SRNA #14 was moved to another unit in the facility following the report by Resident #29 and was allowed to continue to provide direct care for residents. Although the Social Worker/Abuse Coordinator stated she did obtain statements from Resident #29, the resident's daughter, SRNA #14, and a staff nurse assigned to the Seasons Unit, she did not further investigate the alleged incident. The Social Worker/Abuse Coordinator also stated since the resident stated she did not feel the incident was abuse, she did not report the alleged incident to the State Agencies. An additional interview conducted on 04/09/13, at 11:09 AM, with the Social Worker/Abuse Coordinator revealed she was no longer employed by the facility effective 04/08/13 due to illness. During this interview, the Social Worker/Abuse Coordinator stated she routinely reported all allegations to the DON or Administrator; and they would direct her on the procedures to follow when an allegation of abuse was reported, including investigation, protection, and reporting. The Social Worker/Abuse Coordinator stated she had missed doing some things during the investigation of the incident reported by Resident #29. Interview conducted on 04/05/13, at 6:05 PM, with the Vice President of Operations revealed he was currently acting as the facility's Administrator, and was not aware of the incident involving Resident #29. Further interview with the Vice President of Operations on 04/05/13 at 7:30 PM, revealed SRNA #14 continued to work at the facility in the provision of direct care after Resident #29 had reported the incident and was still providing direct resident care on 04/05/13. However, the Vice President of Operations stated SRNA #14 was suspended from employment after he was informed of the alleged incident on 04/05/13. The Vice President of Operations also confirmed no further investigation had been conducted by the facility of the alleged incident and he could provide no evidence the allegation had been reported to the state agencies as directed by the facility's abuse policy. 3. Review of the facility's investigation, initiated by the facility's Social Worker/Abuse Coordinator on 03/24/13, revealed Resident #30 reported on 03/24/13, that on 03/22/13, from 8:00 PM to 9:00 PM, SRNA #13 had sprayed cold water on the resident while in the shower and had wrapped a sheet too tight around the resident's neck. Continued review revealed the investigation was not completed and the allegation was not reported to the appropriate state agencies until 04/09/13, (sixteen days after the incident was reported). It could not be determined by a review of documentation if the facility had protected residents from further potential abuse while the investigation was being conducted, or if the facility allowed SRNA #13 to continue to provide resident care at the facility. According to the initial report, dated 04/09/13, the facility had attempted to contact SRNA #13 to inform the SRNA that she would be suspended and not allowed to work until the investigation had been completed. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13, of the abuse allegation involving Resident #30 that occurred on 03/22/13. According to the Social Worker/Abuse Coordinator the investigation of the allegation had not been completed. Interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 was not aware the allegation of abuse had not been thoroughly investigated and reported as required until the Social Worker/Abuse Coordinator had reported on 04/08/13 that the investigation was not complete. At the time of the interview, Administrator #2 could provide no documentation that any action had taken to ensure residents were protected during the facility's investigation or that the allegation had been reported to the appropriate State Agencies. According to Administrator #2, the allegations were logged in an abuse investigation log at the end of each day. However, review of the facility's investigation log revealed no entry regarding Resident #30. 4. A review of the facility's investigation dated 04/01/13 revealed on 03/27/13, the Administrator was informed that Resident #4 had made an allegation of abuse on 03/24/13, three days prior. According to the investigation, Resident #4 was interviewed on 03/28/13 and reported that no one had been mean to (her/him). When the facility questioned the resident if he/she had alleged someone was mean to him/her the resident stated he/she had told one

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of the women that. According to the facility's investigation, the resident didn't really mean it. The Social Worker/Abuse Coordinator asked the resident if the woman was RN #8 and the resident stated, Yeah my little nurse. Further review of the investigation revealed RN #8 stated Resident #4 did make the statement on 03/24/13 that she was mean to the resident. RN #8 reported she had told the resident to use the call light for assistance instead of getting up on her own. All residents assessed by the facility to be interviewable were interviewed in regards to their treatment. The investigation concluded the allegation of abuse was unsubstantiated based on Resident #4's moderately impaired cognitive ability. Interview with RN #8 on 03/28/13 at 8:07 PM revealed on the morning of 03/24/13 Resident #4 alleged the RN was mean to the resident and Resident #4 did not want RN #8 to come into the resident's room again or provide care for the resident. RN #8 stated she documented the incident in the nurse's notes, and only thought Resident #4 was upset the morning of 03/24/13. However, RN #8 stated she should have told another nurse; removed herself from the floor; and called the Administrator and DON. RN #8 stated the incident didn't seem like an allegation of abuse. Interview with the DON on 04/02/13 at 8:45 PM revealed she was informed of the allegation against RN #8 on 03/24/13 by the Weekend Manager. She stated she did not give the Weekend Manager any further instructions. The DON stated on 03/25/13 she interviewed Resident #4; got side tracked with something else; and did not notify the Administrator or interview RN #8. The DON stated on 03/27/13, the Corporate Nurse Consultant questioned her related to a nurse's note found in Resident #4's medical record related to the incident. The DON stated she called RN #8 and had her come in to work early on the evening of 03/27/13 to obtain an interview. After interviewing the nurse, the DON and Administrator #2 allowed RN #8 to work her scheduled 12-hour shift. The DON stated since RN #8 and Resident #4 denied the allegation, she and Administrator #2 decided abuse did not occur. However, the DON acknowledged the facility's investigation had not been finished at the time of the interview. Interview with Administrator #2 on 03/28/13 at 2:00 PM; 6:40 PM; and on 03/29/13 at 10:25 AM and 4:11 PM revealed he became aware of the incident on 03/27/13, at approximately 5:40 PM, and spoke to the DON regarding the incident. Administrator #2 stated the DON informed him she had forgotten to inform him of the allegation of abuse and failed to initiate an investigation related to the allegation. Further, Administrator #2 stated he sat in during the interview between the DON and RN #8; however, he was half paying attention. Administrator #2 initially stated in interview that he was not aware RN #8 had been permitted to work on 03/27/13 and that he didn't ask (DON) why she didn't remove the alleged perpetrator. Continued interview with Administrator #2 revealed he was aware RN #8 had been permitted to work after the interview had been conducted on 03/27/13 while the investigation was in progress. Interview further revealed Administrator #2 did not think it was reportable and stated, In my heart of hearts I have gotten to know the little girl while I've been here, I just didn't feel it was true and reportable. Further interview revealed Administrator #2 had not interviewed the DON regarding the incident and stated the DON had just forgotten to do anything with the information she received on 03/24/13. Administrator #2 stated RN #8 should have reported the incident to another Charge Nurse on 03/24/13; that he should have been notified of the incident; and, that RN #8 should have been sent home on 03/24/13 following the incident. Continued interview with Administrator #2 on 03/29/13 at 4:11 PM revealed he did concur with the DON on 03/27/13 related to allowing RN #8 to work her shift after the resident stated he/she did not want RN #8 to take care of her. Per interview, he and the DON agreed RN #8 could continue to provide resident care. Administrator #2 further stated in hindsight with the facility the way it is right now allowing the RN to continue to work during the investigation was probably a bad decision. 5. Review of the facility's investigation revealed SRNA #1 and SRNA #8 reported to the facility's Social Worker/Abuse Coordinator that on 04/04/13, they overheard a Lab Technician tell Resident #19 It's going to hurt you worse than it will me because I have a needle stuck in your arm. Even though the investigation revealed the incident had been reported immediately to the facility's Social Worker/Abuse Coordinator on 04/04/13, the facility failed to ensure the allegation was immediately reported to the required state agencies until 04/06/13 (two days after the incident was reported). Interview on 04/09/13 at 2:55 PM with the Corporate Nurse Executive who had completed the investigation of the allegation revealed she initially had not considered the allegation reportable. However, the Corporate Nurse Executive stated as a part of the facility's ongoing audits, the allegation was determined to be an allegation of verbal abuse and was reported to the appropriate State Agencies late, on 04/06/13. The Corporate Nurse Executive stated the allegation being reported late was better than not reporting the allegation. 6. An interview conducted with the facility's Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had informed Administrator #2 on 04/08/13 of an abuse allegation involving Resident #31 but she could not recall the date of the allegation. An interview with Administrator #2 on 04/09/13 at 3:03 PM revealed Administrator #2 could not recall the allegation regarding Resident #31 that was reported on 04/08/13 and an investigation of the allegation had not been initiated. Continued interview with Administrator #2 on 04/09/13 at 5:00 PM revealed Administrator #2 had discussed the allegation reported by the Social Worker/Abuse Coordinator on 04/08/13 with staff and learned there was an allegation that Resident #31 may have been sat down in a chair too hard by facility staff around 3/17-19/13, but no witness statements or investigation could be found. Review of the facility's investigation log revealed no entry regarding the alleged incident involving Resident #31, which was reported on 04/08/13. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: The allegation of abuse against Resident #31 was reported to appropriate State Agencies on 04/09/13 by Administrator #2. The Interim Social Services Director (SSD) completed an interview with Resident #31 and the resident's daughter on 04/09/13. The facility suspended the alleged perpetrator on 04/09/13. Other employees were interviewed by the Vice President of Human Resources and the Regional Human Resources Director on 04/10/13 to identify if any other staff had observed the alleged perpetrator be rude or rough with any other residents. All residents with a BIMS score of seven or above were interviewed by Regional Staff regarding any concerns with rough or rude treatment and no concerns were identified. The allegation of abuse against Resident #19 was reported to the appropriate State Agencies by the Chief Nurse Executive on 04/06/13. A body audit on Resident #19 was completed by the Regional Nurse Consultant on 04/04/13. Statements were obtained from the lab technician, the alleged perpetrator, on 04/08/13. Statements were obtained on 04/04/13 from two staff members who were present during the alleged abuse. The supervisor of the lab technician was notified by the Chief Nurse Executive on 04/04/13 that the facility would no longer utilize the lab technician. The allegation of abuse against Resident #30 was reported to the appropriate State Agencies on 04/09/13 by Administrator #2. The Administrator and the Interim Social Services Director interviewed Resident #30 on 04/10/13 regarding the alleged abuse incident. Statements were obtained on 04/10/13 from the two staff who was the alleged perpetrators. The two alleged perpetrators were suspended on 04/10/13. An interview was completed by the Chief Operating Officer on 04/09/13 with the Nurse who provided care for Resident #30 on the evening of the alleged incident. Interviews were completed by Regional Staff on 04/09/13 with other residents who reside on the same unit as Resident #30, regarding staff treatment during care, with no concerns identified. The allegation of abuse against Resident #29 was reported to the appropriate State Agencies on 04/05/13 by the Chief Nurse Executive. Administrator #2 and the Interim Social Services Director interviewed Resident #29 on 04/05/13 regarding the alleged abuse. The Regional Nurse completed a body audit on Resident #29 on 04/05/13 with no injuries identified. The alleged perpetrator was interviewed by the Vice President of Human Resources and the Chief Operating Officer along with a statement obtained. The alleged perpetrator was suspended on 04/05/13 along with Administrator #1, who was the facility ' s Administrator at the time of the occurrence, Resident ' s with a BIMS score over 7 was interviewed by Department Managers on 04/05/13 and Regional Staff on 04/05/13 regarding other incidents of inappropriate treatments, with no concerns identified. The allegation of abuse by Resident #4 was reported to the appropriate State Agencies on 03/30/13 by Administrator #2 and a final report was submitted on 04/03/13 to the appropriate State Agencies, which unsubstantiated abuse regarding Resident #4. The second allegation of abuse by Resident #4 was submitted to the appropriate State Agencies on 04/09/13. The staff member who was the alleged abuser was suspended during the investigation. A third allegation by Resident #4 was submitted on 04/09/13 regarding a review of an incident report dated 03/28/13 for bruises. The investigation was in progress. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a posttest. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed, will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Independent Contractor initiated continued abuse education regarding identifying, reporting, and ensuring resident safety on 04/11/13. All staff scheduled to work will receive this re-education by 04/12/13. Staff not scheduled to work during that time frame, who work

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET** **BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0226	(continued... from page 30) as needed, or who are on leave of absence will receive the education upon returning to work, by Administrator #2, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Staff Development Coordinator, or Regional Staff. On 04/12/13 thirty-four (34) interviews were conducted by the Department Managers (Staffing Coordinator, Dietary Manager, Housekeeping Director) for residents with a Brief Interview for Mental Status (BIMS) score of seven (7) or above to determine their feelings of safety and identify any allegations of mistreatment or abuse. There were no concerns voiced. A body audit was complete for eighty-one (81) residents, there were an additional nine (9) residents who refused a body audit therefore the audit was not performed on those nine (9), by Administrative Nurses (MDS Coordinators, DON, Staff Development Coordinator), on 04/12/13 and regional nurses (Signature Care Consultants, Internal Audit Director -RN from the Corporate office, Director of Medical Review -RN from the corporate office) for residents with a BIMS score below 7 to ensure that no physical signs and symptoms of abuse were present. Results of body audits did not reflect any physical injuries. On 04/12/13 Department Managers (Dietary Manager, Staffing Coordinator) also met with license nurse and Certified Nurse Assistant (C.N.A.) (State Registered Nurse Aides) assigned to residents with a BIMS of seven (7) or less, thirty-six (36) residents, to interview for any noted change of behavior or any signs of fear. All above interviews were placed in a binder called the AOC binder located In the Administrator's office. Administrator #2, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assist
F 0281	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to ensure services provided met professional standards of quality for eight of twenty-nine sampled residents. On 03/28/13 at 4:00 PM, the facility failed to obtain blood glucose levels (Accuchecks) as ordered by the physicians for Residents #2, #6, #10, #21, and #22. The facility failed to consistently document transactions from the emergency drug kits by failing to complete usage reports for Residents #3 and #9. Additionally, Resident #5 had physician's orders [REDACTED]. The findings include: 1. As a result of observation, interview, and record review, it was determined that staff failed to follow accepted standards of practice by failing to follow facility policy regarding the use of emergency medication kits (i.e., E-Boxes). It was determined that staff did not always document transactions of its E-Boxes by failing to complete and turn in usage reports to both their provider pharmacy and to the facility's Medical Records Department. Because of this practice, the facility was unable to monitor the use of its E-Boxes or account for medications removed from the boxes. Review of the facility's policy related to the use of E-Boxes (Policy #3.4, Emergency Pharmacy Service and Emergency Kits) revealed: A) Item #8 of the policy stated that upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on the emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. B) Item #9 stated that use of emergency medications were to be noted on the resident's current MAR. On 03/28/13 at approximately 2:00 PM, while reviewing the Medication Administration Records (MARs) for residents living on the Seasons Unit, Resident #9 was noted to have received a 10-day regimen of the antibiotic [MEDICATION NAME], 100 milligrams (mg) (one capsule twice daily) for a urinary tract infection. The drug was scheduled for administration at 9:00 AM and 9:00 PM, and the MAR revealed the resident's therapy began on 03/16/13 at 9:00 AM and concluded on 03/25/13 at 9:00 AM, and that all 20 ordered doses were given as ordered. Review of the resident's orders revealed the [MEDICATION NAME] order was posted on 03/15/13, and dispensing records revealed that 20 capsules were delivered from the pharmacy on 03/16/13. The time of delivery would have been at approximately 11:00 PM. Thus, the resident's initial two doses were obtained from a source other than the actual prescription. At 3:00 PM on 03/28/13, the Seasons Unit medication cart was audited and revealed that Resident #9's drawer contained the package of [MEDICATION NAME] 100 mg dispensed by the pharmacy on 03/15/13 for 20 capsules, and although the therapy had concluded on 03/25/13, the container revealed the presence of 12 capsules, leading one to conclude the resident may have failed to receive up to 12 of the 20 ordered doses. At 6:30 PM on 03/28/13, Kentucky Medication Aide (KMA) #3 who was currently passing medications on the Seasons Unit was interviewed concerning Resident #9's extra antibiotics. The aide was shown the resident's medication drawer and acknowledged the resident's drawer still contained [MEDICATION NAME] capsules even though the therapy had been completed since 03/25/13. The aide was shown the resident's MAR and she also acknowledged that all 20 ordered doses had been documented as given. Although KMA #3 was unable to explain why the 12 capsules remained in the drawer, the aide commented that it was very common to initiate a new medication order through use of the facility's E-Boxes. The aide also explained that when a new medication is ordered late in the workday (e.g., after 6:00 PM), the medication may not arrive from the provider pharmacy for approximately 24 hours. In cases such as that, the therapy may be started by using medications from the E-Box or, in some situations, by ordering a 24-hour supply from their backup or secondary pharmacy. During the course of the interview, the unit's E-Box was inspected, showing that it was authorized to contain 4 capsules of [MEDICATION NAME] 100 mg. The aide explained that when removing a medication from the E-Box, staff was expected to fill out a dual copy usage report, with the top (white) copy being placed inside the E-Box for receipt by the pharmacy and the second (yellow) copy to be placed in a receipt box (located near the E-Box) to be forwarded to the Medical Records Department. Although the box contained some yellow copies from previous transactions there were no copies found related to [MEDICATION NAME] obtained for Resident #9. On 04/03/13 at approximately 10:00 AM, the issue of the E-Boxes was discussed with Administrator #2, the Acting DON (Director of Nursing), and the CNE (Chief Nurse Executive). Through a previous request, the Acting DON had provided pharmacy records related to Resident #9's [MEDICATION NAME]. However, they reported they were unable to locate any proof (e.g., usage reports) that any doses of [MEDICATION NAME] had ever been obtained from the E-Box for Resident #9. On 04/03/13 at 2:40 PM, during an interview with the Director of the provider pharmacy, the Director estimated that staff usually failed to fill out and forward usage reports in the E-Box about 50 percent of the time. He also stated that in most instances any usage reports that were placed inside the E-Box would be discarded since they were not used for billing purposes. He further explained that a daily per diem the pharmacy received from the facility would cover the cost of most items removed from the E-Boxes. The Director explained he was unaware of any complaints regarding the facility's use of the E-Boxes, or any complaints regarding any residents not being given their medications as ordered. The Director explained it would be impossible to determine why Resident #9 continued to have the 12 capsules of [MEDICATION NAME] in her drawer. However, he did speculate that because most of their unit dose pills are packaged in strips of 30 pills it would be possible that a tech in the pharmacy could have placed a full strip of 30 inside the prescription box rather than the ordered 20 capsules. Since the resident's first two doses of the [MEDICATION NAME] could have likely been obtained from the E-Box, the Director speculated that that could possibly explain the presence of the 12 capsules in the resident's drawer. As the result of an on-site visit to the facility's backup pharmacy (a pharmacy in the community), it was determined that Resident #9 had no prescription activity over the previous 90 days. 2. During the review on 03/28/13 of the MARs for residents living on the Seasons Unit, Resident #3 was noted to have been treated with a 10-day course of the antibiotic [MEDICATION NAME], 150 mg (one capsule 3 times daily for 10 days) which was initiated at 9:00 AM on 03/14/13 and concluded at 9:00 PM on 03/23/13. The MAR also revealed that all 30 doses had been administered as ordered. The resident's clinical record revealed the order was given by the physician on 03/14/13, and review of the pharmacy's shipping manifest revealed the order was signed upon receipt on 03/14/13. Thus, at least the first three doses would have

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0281	(continued... from page 31) been obtained from a source other than the prescription order. However, inspection of the resident's medication drawer revealed the prescription box still present in the drawer; the package was labeled as having contained 30 capsules, was dispensed on 03/14/13, and still contained 5 capsules, even though the duration of therapy concluded on 03/23/13. Thus, it suggested that the resident could have failed to receive up to 5 of 30 ordered doses. On 03/28/13, KMA #3 was interviewed about Resident #3's [MEDICATION NAME]. KMA #3 attributed the resident's five extra [MEDICATION NAME] capsules to use of the E-Box. Since the pharmacy order was received by the facility at the end of the day on 03/14/13, it would be conceivable that staff had to obtain the resident's first three doses from the E-Box, so the source of the remaining two capsules continued to remain a mystery. The Acting DON and the CNE were unable to obtain evidence that staff had obtained any doses of the [MEDICATION NAME] from the facility's E-Boxes. That was also verified by the facility's Medical Records Director on 04/05/13. Moreover, records at the facility's backup pharmacy revealed Resident #3 did not receive orders for [MEDICATION NAME]. 3. Review of a facility policy, Physician order [REDACTED]. Review of the medical record for Resident #5 revealed the resident's [DIAGNOSES REDACTED]. A review of physician's orders [REDACTED]. Review of Resident #5's comprehensive care plan dated 03/28/13 revealed the resident was to receive oxygen as ordered by the physician. Approaches to implement the care plan were as follows: explain importance of receiving oxygen as Physician orders [REDACTED]. Observation of Resident #5 on 04/01/13 at 4:00 PM revealed the resident leaving the facility's designated smoke room with no oxygen in use. Observations on 04/01/13 at 4:30 PM and 5:00 PM revealed Resident #5 was not wearing oxygen while in the hallway. Observation on 04/01/13 at 5:10 PM revealed Resident #5 returned to his/her room, turned the oxygen on at a setting of 4.5 liters per minute, and put the nasal cannula on. Resident #5 was observed on 04/01/13 at 5:15 PM to be in his/her room and continued to receive the oxygen at 4.5 liters per minute via nasal cannula. Observation at 6:00 PM on 04/01/13 revealed Resident #5 continued to receive oxygen at 4.5 liters per minute via nasal cannula. Interview with Resident #5 on 04/01/13 at 5:10 PM revealed, The doctor told me I could turn up the oxygen if I needed to. Continued observation of Resident #5 on 04/02/13 at 8:15 AM revealed the resident lying in bed with oxygen on at 5 liters per minute via nasal cannula. Observation on 04/02/13 at 9:30 AM revealed Resident #5 was in bed with oxygen on at 3.5 liters per minute via nasal cannula. Observation on 04/02/13 at 9:45 AM revealed Resident #5 was in a wheelchair in the hallway and did not have oxygen on. Observation at 9:50 AM revealed Resident #5 returned to his/her room and was observed to receive oxygen at 5 liters per minute via nasal cannula. Observation on 04/02/13 at 10:30 AM revealed Resident #5 was in bed and was receiving oxygen at 3.5 liters per minute. Additional observations at 11:30 AM and 11:35 AM on 04/02/13 revealed Resident #5 was in the hallway without his/her oxygen in use and, at 11:35 AM, requested staff to obtain his/her blood pressure. Facility staff obtained the resident's blood pressure and the resident returned to his/her room. At the time the resident returned to his/her room, the oxygen concentrator was observed to be set at 5 liters per minute; however, Resident #5 did not have the nasal cannula on and was not receiving the oxygen. Observation on 04/02/13 at 12:30 PM revealed Resident #5 had oxygen in use at 5 liters per minute; however, at that time RN #5 adjusted the resident's oxygen to 2 liters per minute, obtained the resident's pulse oxygenation, and noted the results of the pulse oxygenation to be 97 percent. Resident #5 did not appear to be having trouble breathing during the observations for 04/01/13 through 04/02/13. Interview with SRNA #11 on 04/02/13 at 12:15 PM revealed Resident #5's oxygen was supposed to be on 2 liters per minute via nasal cannula. The SRNA stated she was not permitted to adjust the resident's oxygen, and if she thought the oxygen needed adjusting she informed the nurse. The SRNA stated the nurses were supposed to monitor each resident's oxygen use. SRNA #11 stated, It could be a problem, if the oxygen level was too high for a resident. Interview with SRNA #13 on 04/02/13 at 12:20 PM revealed Resident #5 was very independent and rarely needed anything. SRNA #13 stated Resident #5 was supposed to have oxygen on at 2 liters per minute via nasal cannula and, according to SRNA #13, if the resident's oxygen setting was too high, the SRNA notified the nurse, and the nurse would change the oxygen level if needed. According to SRNA #13, Resident #5 had turned up his/her oxygen level a few weeks ago, and she informed the resident's nurse. Interview with Registered Nurse (RN) #5 on 04/02/13 at 12:30 PM revealed on 04/02/13 at 12:15 PM, SRNA #11 reported Resident #5's oxygen administration setting was on 5 liters per minute and RN #5 adjusted the oxygen setting to 2 liters per minute as ordered by the physician. On 04/02/13 at 12:30 PM at request of the surveyor, RN #5 went to Resident #5's room and observed the resident's oxygen administration level to be at 5 liters per minute. RN #5 adjusted the oxygen administration level to 2 liters per minute and stated the physician's orders [REDACTED]. RN #5 stated she had only worked four days on Resident #5's nursing unit, was unfamiliar with Resident #5, and was not aware Resident #5 adjusted his/her oxygen setting at times. 4. The facility admitted Resident #22 on 12/20/12, with [DIAGNOSES REDACTED]. A review of Resident #22's Admission Minimum Data Set (MDS) assessment completed on 12/28/12 revealed the facility assessed the resident to have a cognitive summary score of 12, to require extensive assistance for locomotion and limited assistance for all other activities of daily living. A review of Resident #22's Comprehensive Care Plan dated 03/18/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. Review of Resident #22's physician's orders [REDACTED]. Observation of Resident #22 on 03/28/13 at 6:04 PM revealed the resident was complaining of a dry mouth to a Medication Administration Aide, stating, Honey, I'm so thirsty; they always check my sugar before supper but they didn't do it. I think I may need some insulin. Review of Resident #22's Treatment Administration Record (TAR) revealed the facility had failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. 5. The facility admitted Resident #6 on 12/28/11, with [DIAGNOSES REDACTED]. A review of Resident #6's Quarterly MDS assessment completed on 01/02/13 revealed the facility assessed the resident to have no cognitive impairment and to be independent with bed mobility, transfers, and ambulation. A review of Resident #6's Comprehensive Care Plan dated 01/02/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. Review of Resident #6's physician's orders [REDACTED]. Review of Resident #6's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. 6. The facility admitted Resident #2 on 07/28/12, with [DIAGNOSES REDACTED]. A review of Resident #2's Comprehensive Care Plan dated 02/16/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. A review of Resident #2's Quarterly MDS assessment completed on 02/25/13 revealed the facility assessed the resident to have moderate cognitive impairment and to require extensive assistance with all activities of daily living. Review of Resident #2's physician's orders [REDACTED]. Review of Resident #2's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. Interview with Resident #2 on 03/02/13 at 3:16 PM revealed the resident denied any problems related to not receiving the Accucheck as ordered on [DATE]. 7. The facility admitted Resident #21 on 04/17/12, with [DIAGNOSES REDACTED]. A review of Resident #21's Comprehensive Care Plan dated 02/16/12, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. A review of Resident #21's Quarterly MDS assessment completed on 12/26/12 revealed the facility assessed the resident to have a cognitive summary score of 12, to require supervision for eating and extensive assistance with all other activities of daily living. Review of Resident #21's physician's orders [REDACTED]. Review of Resident #21's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. Interview with Resident #21 on 03/29/13 at 3:18 PM revealed the resident denied any problems related to the Accucheck not being obtained as ordered on [DATE], stating, Oh yeah, I'm fine. 8. The facility admitted Resident #10 on 12/13/12, with [DIAGNOSES REDACTED]. A review of Resident #10's Quarterly MDS assessment completed on 03/04/13 revealed the facility assessed the resident to have a cognitive summary score of 13, and to require supervision/limited assistance for all activities of daily living. A review of Resident #10's Comprehensive Care Plan dated 03/04/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. Review of Resident #10's physician's orders [REDACTED]. Review of Resident #10's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. Interview with Resident #10 on 03/29/13 at 3:13 PM revealed the resident denied any problems related to the Accucheck not being obtained as ordered on [DATE]. Interview with the Staff Development Coordinator (SDC) at 8:05 PM on 03/28/13, revealed she was told by Administration sometime after 4:00 PM (exact time unknown) to cover the Seasons Unit, related to the assigned nurse being removed from direct patient care. The SDC stated that she received no report prior to being assigned to care for the residents and had no communication with the prior nurse. The SDC stated she was unaware that Accuchecks had not been obtained for residents on the Seasons Unit. Interview with Administrator #2 on 03/28/13 at 8:00 PM confirmed the nurse assigned to the Seasons Unit was removed from direct patient care after an allegation of abuse was made. The Administrator stated the SDC was assigned to cover the floor, but made no provisions to ensure the continuity of resident care, such as ensuring a detailed report was provided to the SDC of what care needs the residents required, or what nursing tasks needed to be completed.

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NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**	

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F 0281	(continued... from page 32)
F 0281	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to ensure services provided met professional standards of quality for eight of twenty-nine sampled residents. On 03/28/13 at 4:00 PM, the facility failed to obtain blood glucose levels (Accuchecks) as ordered by the physicians for Residents #2, #6, #10, #21, and #22. The facility failed to consistently document transactions from the emergency drug kits by failing to complete usage reports for Residents #3 and #9. Additionally, Resident #5 had physician's orders [REDACTED]. The findings include: 1. As a result of observation, interview, and record review, it was determined that staff failed to follow accepted standards of practice by failing to follow facility policy regarding the use of emergency medication kits (i.e., E-Boxes). It was determined that staff did not always document transactions of its E-Boxes by failing to complete and turn in usage reports to both their provider pharmacy and to the facility's Medical Records Department. Because of this practice, the facility was unable to monitor the use of its E-Boxes or account for medications removed from the boxes. Review of the facility's policy related to the use of E-Boxes (Policy #3.4, Emergency Pharmacy Service and Emergency Kits) revealed: A) Item #8 of the policy stated that upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on the emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. B) Item #9 stated that use of emergency medications were to be noted on the resident's current MAR. On 03/28/13 at approximately 2:00 PM, while reviewing the Medication Administration Records (MARs) for residents living on the Seasons Unit, Resident #9 was noted to have received a 10-day regimen of the antibiotic [MEDICATION NAME], 100 milligrams (mg) (one capsule twice daily) for a urinary tract infection. The drug was scheduled for administration at 9:00 AM and 9:00 PM, and the MAR revealed the resident's therapy began on 03/16/13 at 9:00 AM and concluded on 03/25/13 at 9:00 AM, and that all 20 ordered doses were given as ordered. Review of the resident's orders revealed the [MEDICATION NAME] order was posted on 03/15/13, and dispensing records revealed that 20 capsules were delivered from the pharmacy on 03/16/13. The time of delivery would have been at approximately 11:00 PM. Thus, the resident's initial two doses were obtained from a source other than the actual prescription. At 3:00 PM on 03/28/13, the Seasons Unit medication cart was audited and revealed that Resident #9's drawer contained the package of [MEDICATION NAME] 100 mg dispensed by the pharmacy on 03/15/13 for 20 capsules, and although the therapy had concluded on 03/25/13, the container revealed the presence of 12 capsules, leading one to conclude the resident may have failed to receive up to 12 of the 20 ordered doses. At 6:30 PM on 03/28/13, Kentucky Medication Aide (KMA) #3 who was currently passing medications on the Seasons Unit was interviewed concerning Resident #9's extra antibiotics. The aide was shown the resident's medication drawer and acknowledged the resident's drawer still contained [MEDICATION NAME] capsules even though the therapy had been completed since 03/25/13. The aide was shown the resident's MAR and she also acknowledged that all 20 ordered doses had been documented as given. Although KMA #3 was unable to explain why the 12 capsules remained in the drawer, the aide commented that it was very common to initiate a new medication order through use of the facility's E-Boxes. The aide also explained that when a new medication is ordered late in the workday (e.g., after 6:00 PM), the medication may not arrive from the provider pharmacy for approximately 24 hours. In cases such as that, the therapy may be started by using medications from the E-Box or, in some situations, by ordering a 24-hour supply from their backup or secondary pharmacy. During the course of the interview, the unit's E-Box was inspected, showing that it was authorized to contain 4 capsules of [MEDICATION NAME] 100 mg. The aide explained that when removing a medication from the E-Box, staff was expected to fill out a dual copy usage report, with the top (white) copy being placed inside the E-Box for receipt by the pharmacy and the second (yellow) copy to be placed in a receipt box (located near the E-Box) to be forwarded to the Medical Records Department. Although the box contained some yellow copies from previous transactions there were no copies found related to [MEDICATION NAME] obtained for Resident #9. On 04/03/13 at approximately 10:00 AM, the issue of the E-Boxes was discussed with Administrator #2, the Acting DON (Director of Nursing), and the CNE (Chief Nurse Executive). Through a previous request, the Acting DON had provided pharmacy records related to Resident #9's [MEDICATION NAME]. However, they reported they were unable to locate any proof (e.g., usage reports) that any doses of [MEDICATION NAME] had ever been obtained from the E-Box for Resident #9. On 04/03/13 at 2:40 PM, during an interview with the Director of the provider pharmacy, the Director estimated that staff usually failed to fill out and forward usage reports in the E-Box about 50 percent of the time. He also stated that in most instances any usage reports that were placed inside the E-Box would be discarded since they were not used for billing purposes. He further explained that a daily per diem the pharmacy received from the facility would cover the cost of most items removed from the E-Boxes. The Director explained he was unaware of any complaints regarding the facility's use of the E-Boxes, or any complaints regarding any residents not being given their medications as ordered. The Director explained it would be impossible to determine why Resident #9 continued to have the 12 capsules of [MEDICATION NAME] in her drawer. However, he did speculate that because most of their unit dose pills are packaged in strips of 30 pills it would be possible that a tech in the pharmacy could have placed a full strip of 30 inside the prescription box rather than the ordered 20 capsules. Since the resident's first two doses of the [MEDICATION NAME] could have likely been obtained from the E-Box, the Director speculated that that could possibly explain the presence of the 12 capsules in the resident's drawer. As the result of an on-site visit to the facility's backup pharmacy (a pharmacy in the community), it was determined that Resident #9 had no prescription activity over the previous 90 days. 2. During the review on 03/28/13 of the MARs for residents living on the Seasons Unit, Resident #3 was noted to have been treated with a 10-day course of the antibiotic [MEDICATION NAME], 150 mg (one capsule 3 times daily for 10 days) which was initiated at 9:00 AM on 03/14/13 and concluded at 9:00 PM on 03/23/13. The MAR also revealed that all 30 doses had been administered as ordered. The resident's clinical record revealed the order was given by the physician on 03/14/13, and review of the pharmacy's shipping manifest revealed the order was signed upon receipt on 03/14/13. Thus, at least the first three doses would have been obtained from a source other than the prescription order. However, inspection of the resident's medication drawer revealed the prescription box still present in the drawer; the package was labeled as having contained 30 capsules, was dispensed on 03/14/13, and still contained 5 capsules, even though the duration of therapy concluded on 03/23/13. Thus, it suggested that the resident could have failed to receive up to 5 of 30 ordered doses. On 03/28/13, KMA #3 was interviewed about Resident #3's [MEDICATION NAME]. KMA #3 attributed the resident's five extra [MEDICATION NAME] capsules to use of the E-Box. Since the pharmacy order was received by the facility at the end of the day on 03/14/13, it would be conceivable that staff had to obtain the resident's first three doses from the E-Box, so the source of the remaining two capsules continued to remain a mystery. The Acting DON and the CNE were unable to obtain evidence that staff had obtained any doses of the [MEDICATION NAME] from the facility's E-Boxes. That was also verified by the facility's Medical Records Director on 04/05/13. Moreover, records at the facility's backup pharmacy revealed Resident #3 did not receive orders for [MEDICATION NAME]. 3. Review of a facility policy, Physician order [REDACTED]. Review of the medical record for Resident #5 revealed the resident's [DIAGNOSES REDACTED]. A review of physician's orders [REDACTED]. Review of Resident #5's comprehensive care plan dated 03/28/13 revealed the resident was to receive oxygen as ordered by the physician. Approaches to implement the care plan were as follows: explain importance of receiving oxygen as Physician orders [REDACTED]. Observation of Resident #5 on 04/01/13 at 4:00 PM revealed the resident leaving the facility's designated smoke room with no oxygen in use. Observations on 04/01/13 at 4:30 PM and 5:00 PM revealed Resident #5 was not wearing oxygen while in the hallway. Observation on 04/01/13 at 5:10 PM revealed Resident #5 returned to his/her room, turned the oxygen on at a setting of 4.5 liters per minute, and put the nasal cannula on. Resident #5 was observed on 04/01/13 at 5:15 PM to be in his/her room and continued to receive the oxygen at 4.5 liters per minute via nasal cannula. Observation at 6:00 PM on 04/01/13 revealed Resident #5 continued to receive oxygen at 4.5 liters per minute via nasal cannula. Interview with Resident #5 on 04/01/13 at 5:10 PM revealed, The doctor told me I could turn up the oxygen if I needed to. Continued observation of Resident #5 on 04/02/13 at 8:15 AM revealed the resident lying in bed with oxygen on at 5 liters per minute via nasal cannula. Observation

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	185337	A. BUILDING ______ B. WING _____	04/09/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	246 EAST MAIN STREET BEATTYVILLE, KY 41311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0281

(continued... from page 33)
on 04/02/13 at 9:30 AM revealed Resident #5 was in bed with oxygen on at 3.5 liters per minute via nasal cannula. Observation on 04/02/13 at 9:45 AM revealed Resident #5 was in a wheelchair in the hallway and did not have oxygen on. Observation at 9:50 AM revealed Resident #5 returned to his/her room and was observed to receive oxygen at 5 liters per minute via nasal cannula. Observation on 04/02/13 at 10:30 AM revealed Resident #5 was in bed and was receiving oxygen at 3.5 liters per minute. Additional observations at 11:30 AM and 11:35 AM on 04/02/13 revealed Resident #5 was in the hallway without his/her oxygen in use and, at 11:35 AM, requested staff to obtain his/her blood pressure. Facility staff obtained the resident's blood pressure and the resident returned to his/her room. At the time the resident returned to his/her room, the oxygen concentrator was observed to be set at 5 liters per minute; however, Resident #5 did not have the nasal cannula on and was not receiving the oxygen. Observation on 04/02/13 at 12:30 PM revealed Resident #5 had oxygen in use at 5 liters per minute; however, at that time RN #5 adjusted the resident's oxygen to 2 liters per minute, obtained the resident's pulse oxygenation, and noted the results of the pulse oxygenation to be 97 percent. Resident #5 did not appear to be having trouble breathing during the observations for 04/01/13 through 04/02/13. Interview with SRNA #11 on 04/02/13 at 12:15 PM revealed Resident #5's oxygen was supposed to be on 2 liters per minute via nasal cannula. The SRNA stated she was not permitted to adjust the resident's oxygen, and if she thought the oxygen needed adjusting she informed the nurse. The SRNA stated the nurses were supposed to monitor each resident's oxygen use. SRNA #11 stated, It could be a problem, if the oxygen level was too high for a resident. Interview with SRNA #13 on 04/02/13 at 12:20 PM revealed Resident #5 was very independent and rarely needed anything. SRNA #13 stated Resident #5 was supposed to have oxygen on at 2 liters per minute via nasal cannula and, according to SRNA #13, if the resident's oxygen setting was too high, the SRNA notified the nurse, and the nurse would change the oxygen level if needed. According to SRNA #13, Resident #5 had turned up his/her oxygen level a few weeks ago, and she informed the resident's nurse. Interview with Registered Nurse (RN) #5 on 04/02/13 at 12:30 PM revealed on 04/02/13 at 12:15 PM, SRNA #11 reported Resident #5's oxygen administration setting was on 5 liters per minute and RN #5 adjusted the oxygen setting to 2 liters per minute as ordered by the physician. On 04/02/13 at 12:30 PM at request of the surveyor, RN #5 went to Resident #5's room and observed the resident's oxygen administration level to be at 5 liters per minute. RN #5 adjusted the oxygen administration level to 2 liters per minute and stated the physician's orders [REDACTED]. RN #5 stated she had only worked four days on Resident #5's nursing unit, was unfamiliar with Resident #5, and was not aware Resident #5 adjusted his/her oxygen setting at times. 4. The facility admitted Resident #22 on 12/20/12, with [DIAGNOSES REDACTED]. A review of Resident #22's Admission Minimum Data Set (MDS) assessment completed on
12/28/12 revealed the facility assessed the resident to have a cognitive summary score of 12, to require extensive assistance for locomotion and limited assistance for all other activities of daily living. A review of Resident #22's Comprehensive Care Plan dated 03/18/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. Review of Resident #22's physician's orders [REDACTED]. Observation of Resident #22 on 03/28/13 at 6:04 PM revealed the resident was complaining of a dry mouth to a Medication Administration Aide, stating, Honey, I'm so thirsty; they always check my sugar before supper but they didn't do it. I think I may need some insulin. Review of Resident #22's Treatment Administration Record (TAR) revealed the facility had failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. 5. The facility admitted Resident #6 on 12/28/11, with [DIAGNOSES REDACTED]. A review of Resident #6's Quarterly MDS assessment completed on 01/02/13 revealed the facility assessed the resident to have no cognitive impairment and to be independent with bed mobility, transfers, and ambulation. A review of Resident #6's Comprehensive Care Plan dated 01/02/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. Review of Resident #6's physician's orders [REDACTED]. Review of Resident #6's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. 6. The facility admitted Resident #2 on 07/28/12, with [DIAGNOSES REDACTED]. A review of Resident #2's Comprehensive Care Plan dated 02/16/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. A review of Resident #2's Quarterly MDS assessment completed on 02/25/13 revealed the facility assessed the resident to have moderate cognitive impairment and to require extensive assistance with all activities of daily living. Review of Resident #2's physician's orders [REDACTED]. Review of Resident #2's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. Interview with Resident #2 on 03/02/13 at 3:16 PM revealed the resident denied any problems related to not receiving the Accucheck as ordered on [DATE]. 7. The facility admitted Resident #21 on 04/17/12, with [DIAGNOSES REDACTED]. A review of Resident #21's Comprehensive Care Plan dated 02/16/12, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. A review of Resident #21's Quarterly MDS assessment completed on 12/26/12 revealed the facility assessed the resident to have a cognitive summary score of 12, to require supervision for eating and extensive assistance with all other activities of daily living. Review of Resident #21's physician's orders [REDACTED]. Review of Resident #21's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. Interview with Resident #21 on 03/29/13 at 3:18 PM revealed the resident denied any problems related to the Accucheck not being obtained as ordered on [DATE], stating, Oh yeah, I'm fine. 8. The facility admitted Resident #10 on 12/13/12, with [DIAGNOSES REDACTED]. A review of Resident #10's Quarterly MDS assessment completed on 03/04/13 revealed the facility assessed the resident to have a cognitive summary score of 13, and to require supervision/limited assistance for all activities of daily living. A review of Resident #10's Comprehensive Care Plan dated 03/04/13, revealed the resident was at risk for hyper/[DIAGNOSES REDACTED], and the facility was to obtain Accuchecks as ordered by the physician. Review of Resident #10's physician's orders [REDACTED]. Review of Resident #10's TAR on 03/28/13, at 6:15 PM revealed the facility failed to obtain the resident's 4:00 PM Accucheck as ordered by the physician. Interview with Resident #10 on 03/29/13 at 3:13 PM revealed the resident denied any problems related to the Accucheck not being obtained as ordered on [DATE]. Interview with the Staff Development Coordinator (SDC) at 8:05 PM on 03/28/13, revealed she was told by Administration sometime after 4:00 PM (exact time unknown) to cover the Seasons Unit, related to the assigned nurse being removed from direct patient care. The SDC stated that she received no report prior to being assigned to care for the residents and had no communication with the prior nurse. The SDC stated she was unaware that Accuchecks had not been obtained for residents on the Seasons Unit. Interview with Administrator #2 on 03/28/13 at 8:00 PM confirmed the nurse assigned to the Seasons Unit was removed from direct patient care after an allegation of abuse was made. The Administrator stated the SDC was assigned to cover the floor, but made no provisions to ensure the continuity of resident care, such as ensuring a detailed report was provided to the SDC of what care needs the residents required, or what nursing tasks needed to be completed.

F 0282

Provide care by qualified persons according to each resident's written plan of care.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure services were provided in accordance with the care plan for one of twenty-nine sampled residents (Resident #19). Resident #19's care plan directed staff to utilize the bed in the lowest position and a fall mat on the floor at the bedside. However, observations on 04/01/13 and 04/12/13 revealed staff failed to ensure Resident #19's bed was in the low position and that there was a fall mat on the floor. The findings include: A review of the facility's Care Plan policy (dated December 2010) revealed the care plan would be implemented through the integration of assessment findings. A review of the medical record revealed the facility admitted Resident #19 on 08/04/04 with [DIAGNOSES REDACTED]. Further review of the medical record revealed the facility assessed the resident to be at risk for falls related to history of falls and fractures. A review of the comprehensive care plan dated 01/19/13 revealed facility staff was to utilize a low bed for Resident #19 with a fall mat beside the bed. In addition, a review of the Nurse Aide Care Plan (guide for direct care staff) also revealed the resident's bed was to be in a low position and a fall mat was to be placed on the floor beside the bed. Observations at 2:50 PM, 4:02 PM, and 5:30 PM on 04/01/13, and at 8:25 AM, 9:35 AM, 11:25 AM, and 12:45 PM on 04/02/13 revealed Resident #19's bed was at the normal height, and there was no mat on the floor beside the bed. Interview with State Registered Nurse Aide (SRNA) #9 at 9:30 AM on 04/03/13 revealed she knew the low bed and mat on the floor were listed in the additional notes on the SRNA care plan, but stated a nurse had told her the use of the low bed and mat on the floor had been discontinued, therefore she had not placed the mat on the floor or the bed in the lowest position. An interview

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NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0282	(continued... from page 34) was conducted with Registered Nurse (RN) #5 at 9:35 AM on 04/03/13. The RN stated the low bed and the use of the mat on the floor had been discontinued. However, after reviewing the medical record the RN acknowledged the order was current and had not been discontinued.
F 0282	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure services were provided in accordance with the care plan for one of twenty-nine sampled residents (Resident #19). Resident #19's care plan directed staff to utilize the bed in the lowest position and a fall mat on the floor at the bedside. However, observations on 04/01/13 and 04/12/13 revealed staff failed to ensure Resident #19's bed was in the low position and that there was a fall mat on the floor. The findings include: A review of the facility's Care Plan policy (dated December 2010) revealed the care plan would be implemented through the integration of assessment findings. A review of the medical record revealed the facility admitted Resident #19 on 08/04/04 with [DIAGNOSES REDACTED]. Further review of the medical record revealed the facility assessed the resident to be at risk for falls related to history of falls and fractures. A review of the comprehensive care plan dated 01/19/13 revealed facility staff was to utilize a low bed for Resident #19 with a fall mat beside the bed. In addition, a review of the Nurse Aide Care Plan (guide for direct care staff) also revealed the resident's bed was to be in a low position and a fall mat was to be placed on the floor beside the bed. Observations at 2:50 PM, 4:02 PM, and 5:30 PM on 04/01/13, and at 8:25 AM, 9:35 AM, 11:25 AM, and 12:45 PM on 04/02/13 revealed Resident #19's bed was at the normal height, and there was no mat on the floor beside the bed. Interview with State Registered Nurse Aide (SRNA) #9 at 9:30 AM on 04/03/13 revealed she knew the low bed and mat on the floor were listed in the additional notes on the SRNA care plan, but stated a nurse had told her the use of the low bed and mat on the floor had been discontinued, therefore she had not placed the mat on the floor or the bed in the lowest position. An interview was conducted with Registered Nurse (RN) #5 at 9:35 AM on 04/03/13. The RN stated the low bed and the use of the mat on the floor had been discontinued. However, after reviewing the medical record the RN acknowledged the order was current and had not been discontinued.
F 0332	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure it was free from medication error rates of five percent or greater. Medication pass observations conducted on 03/28/13, 03/29/13, 04/01/13, and 04/02/13 resulted in the assessment of three medication errors (Residents #1 and #5 and unsampled Resident D) out of fifty-two opportunities, for a medication error rate of 5.76 percent. The findings include: 1. Resident D received nourishment and oral medications via a feeding tube. During the morning medication pass on 04/02/13 at 9:30 AM, the resident was observed to have six oral dosage forms which included four tablet dosage forms (Aspirin 81 milligrams (mg), [MEDICATION NAME] 10 mg, [MEDICATION NAME] 150 mg, and a Multivitamin with Minerals). During the preparation of the medications, Licensed Practical Nurse (LPN) #4 was observed to crush the four tablets and mix the resultant powders in a dose cup. During the administration procedure, the nurse checked the placement of the resident's tube, checked the tube's residual, and then performed an initial flush of the tube with approximately 30 milliliters (ml) of water. The nurse then separately administered two liquid dosage forms (the liquid contents of two fish oil capsules and 2.5 ml of [MEDICATION NAME] Acid Syrup), both of which had been diluted with a small portion of water. The nurse then administered the mixture of the crushed tablets mixed with a small amount of water (approximately 30 ml) followed by a liberal post-flush with more water. Before leaving the room, the nurse concluded the care by administering a bolus feeding consisting of a can of [MEDICATION NAME] 1.2. Following the medication pass observation, review of Resident D's clinical record revealed no evidence of a physician's orders [REDACTED]. A review of the facility's policy related to administration of medications via feeding tube (Policy 7.10, titled Enteral Tubes, dated 12/12) was conducted. Item #10 of the policy stated, Medication administration and flushing of the tube after each individual medication is given if required if there are known compatibility problems between the medications to be mixed together. A minimum of one flush before and after giving the medications is acceptable unless there is a physician's orders [REDACTED]. However, recently long-term care facilities and State Survey Agencies were both reminded of the need to administer all medications separately and to provide individual water flushes between each medication given through a feeding tube. In addition, several professional associations do note that the need to administer all medications separately and to flush between all medications is an accepted standard of practice; notable associations included the Institute for Safe Medication Practices (ISMP), Nursing Times, American Journal of Health-System Pharmacy, Texas Department of Aging and Disability Services, and others. On 04/02/13 at 5:00 PM, LPN #4 was interviewed concerning the issue over the need to administer all medications separately when administering via a feeding tube. The nurse acknowledged she had administered the medications via feeding tube to Resident D that morning according to facility policy, but noted that she had been told by other staff following the medication pass that the current acceptable standard was now to administer the medications separately with in-between flushes, unless otherwise directed by the physician. 2. Observations of Medication Aide #7 administering medication on 03/28/13, at 1:36 PM revealed staff obtained Resident #5's Proair HFA inhaler from the medication cart and handed it to the resident for self-administration. However, the Medication Aide failed to provide Resident #5 with any instruction, direction, or reminders for accurately self-administering the medication. Resident #5 placed the inhaler to his mouth and quickly inhaled two puffs without any time elapsing between inhalations. Review of a large red manufacturer's warning label on the box the Medication Aide removed the Proair HFA inhaler from, prior to giving it to Resident #5, revealed waiting one minute between inhalations was required. Review of Resident #5's Comprehensive Care Plan dated 03/20/13, revealed the resident was unsafe to self-administer medication and would be administered medications by staff. An interview with Medication Aide #7 on 03/28/13, at 2:40 PM, revealed she did not provide a reminder to Resident #7 to wait between inhalation because he is pretty competent, I guess he was in a hurry, he does what he wants to. 3. Observations of Medication Aide #3 administering Resident #1's routine scheduled 5:00 PM medication on 03/28/13, at 4:50 PM revealed the resident had been scheduled to receive [MEDICATION NAME] 100 mg at 3:00 PM, but had not been administered the medication as ordered. Medication Aide #3 stated in an interview on 03/28/13, at 5:00 PM that she must have overlooked the medication and failed to administer the [MEDICATION NAME] at the scheduled time. The observations of the medication pass were reported to Administrator #2, the Acting Director of Nursing, and the Chief Nurse Executive on 04/04/13 at 10:00 AM. The Acting Director of Nursing acknowledged she was aware of the standard of practice regarding the need to administer tube medications separately, and to flush between the medications administered through the tube.
F 0332	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure it was free from medication error rates of five percent or greater. Medication pass observations conducted on 03/28/13, 03/29/13, 04/01/13, and 04/02/13 resulted in the assessment of three medication errors (Residents #1 and #5 and unsampled Resident D) out of fifty-two opportunities, for a medication error rate of 5.76 percent. The findings include: 1. Resident D received nourishment and oral medications via a feeding tube. During the morning medication pass on 04/02/13 at 9:30 AM, the resident was observed to have six oral dosage forms which included four tablet dosage forms (Aspirin 81 milligrams (mg), [MEDICATION NAME] 10 mg, [MEDICATION NAME] 150 mg, and a Multivitamin with Minerals). During the preparation of the medications, Licensed Practical Nurse (LPN) #4 was observed to crush the four tablets and mix the resultant powders in a dose cup. During the administration procedure, the nurse checked the placement of the resident's tube, checked the tube's residual, and then performed an initial flush of the tube with approximately 30 milliliters (ml) of water. The nurse then separately administered two liquid dosage forms (the liquid contents of two fish oil capsules and 2.5 ml of [MEDICATION NAME] Acid Syrup), both of which had been diluted with a small portion of water. The nurse then administered the mixture of the crushed tablets mixed with a small amount of water (approximately 30 ml) followed by a liberal post-flush with more water. Before leaving the room, the nurse concluded the care by administering a bolus feeding consisting of a can of [MEDICATION NAME] 1.2. Following the medication pass observation, review of Resident D's clinical record revealed no evidence of a physician's orders [REDACTED]. A review of the facility's policy related to administration of medications via feeding tube (Policy 7.10, titled Enteral Tubes, dated 12/12) was conducted. Item #10 of the policy stated, Medication

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F 0332

(continued... from page 35)
administration and flushing of the tube after each individual medication is given if required if there are known compatibility problems between the medications to be mixed together. A minimum of one flush before and after giving the medications is acceptable unless there is a physician's orders [REDACTED]. However, recently long-term care facilities and State Survey Agencies were both reminded of the need to administer all medications separately and to provide individual water flushes between each medication given through a feeding tube. In addition, several professional associations do note that the need to administer all medications separately and to flush between all medications is an accepted standard of practice; notable associations included the Institute for Safe Medication Practices (ISMP), Nursing Times, American Journal of Health-System Pharmacy, Texas Department of Aging and Disability Services, and others. On 04/02/13 at 5:00 PM, LPN #4 was interviewed concerning the issue over the need to administer all medications separately when administering via a feeding tube. The nurse acknowledged she had administered the medications via feeding tube to Resident D that morning according to facility policy, but noted that she had been told by other staff following the medication pass that the current acceptable standard was now to administer the medications separately with in-between flushes, unless otherwise directed by the physician.

2. Observations of Medication Aide #7 administering medication on 03/28/13, at 1:36 PM revealed staff obtained Resident #5's Proair HFA inhaler from the medication cart and handed it to the resident for self-administration. However, the Medication Aide failed to provide Resident #5 with any instruction, direction, or reminders for accurately self-administering the medication. Resident #5 placed the inhaler to his mouth and quickly inhaled two puffs without any time elapsing between inhalations. Review of a large red manufacturer's warning label on the box the Medication Aide removed the Proair HFA inhaler from, prior to giving it to Resident #5, revealed waiting one minute between inhalations was required. Review of Resident #5's Comprehensive Care Plan dated 03/20/13, revealed the resident was unsafe to self-administer medication and would be administered medications by staff. An interview with Medication Aide #7 on 03/28/13, at 2:40 PM, revealed she did not provide a reminder to Resident #7 to wait between inhalation because he is pretty competent, I guess he was in a hurry, he does what he wants to. 3. Observations of Medication Aide #3 administering Resident #1's routine scheduled 5:00 PM medication on 03/28/13, at 4:50 PM revealed the resident had been scheduled to receive [MEDICATION NAME] 100 mg at 3:00 PM, but had not been administered the medication as ordered. Medication Aide #3 stated in an interview on 03/28/13, at 5:00 PM that she must have overlooked the medication and failed to administer the [MEDICATION NAME] at the scheduled time. The observations of the medication pass were reported to Administrator #2, the Acting Director of Nursing, and the Chief Nurse Executive on 04/04/13 at 10:00 AM. The Acting Director of Nursing acknowledged she was aware of the standard of practice regarding the need to administer tube medications separately, and to flush between the medications administered through the tube.

F 0333

Make sure that residents are safe from serious medication errors.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure residents were free of significant medication errors for one of twenty-nine sampled residents (Resident #9). On 03/28/13 at 4:00 PM, the facility failed to administer Resident #9's physician ordered insulin. The findings include: A review of the facility policy, Medication Administration-Administering Medications, dated December 2010, revealed medications were to be administered only as ordered by a physician. Staff was to chart on the medication sheet and/or nurse's notes any failure to administer medication, regardless of the reason. The facility admitted Resident #9 on 11/30/12, with [DIAGNOSES REDACTED]. A review of Resident #9's Quarterly Minimum Data Set (MDS) assessment completed on 03/04/13 revealed the facility assessed the resident to have a cognitive summary score of 13 and to require supervision/limited assistance for all activities of daily living. A review of Resident #9's Comprehensive Care Plan dated 03/04/13, revealed a problem of uncontrolled Diabetes, and the resident was to receive medications as ordered by the physician. Review of Resident #9's physician's orders dated March 2013 revealed staff was to administer to Resident #9 30 units of [MEDICATION NAME] 70/30 insulin every evening at 4:00 PM. Review of Resident #9's Treatment Administration Record (TAR) at 6:15 PM revealed the resident had not been administered the insulin as ordered. Observation of Resident #9 on 03/29/13 at 3:12 PM, revealed the resident to be sitting up on the bed. Resident #1 denied any problems related to the insulin not being administered as ordered on [DATE]. Interview with the Staff Development Coordinator (SDC) at 8:05 PM on 03/28/13, revealed she was told by Administration sometime after 4:00 PM (exact time unknown) to cover the Seasons Unit, related to the assigned nurse being removed from direct patient care. The SDC stated that she received no report prior to being assigned to care for the residents and had no communication with the prior nurse. The SDC stated she was unaware that Accuchecks had not been obtained for residents on the Seasons Unit. Interview with Administrator #2 on 03/28/13 at 8:00 PM confirmed the nurse assigned to the Seasons Unit was removed from direct patient care after an allegation of abuse was made. Administrator #2 stated the SDC was assigned to cover the floor but Administrator #2 had made no provisions to ensure the continuity of resident care, such as ensuring the SDC received a detailed report of what care needs the residents required, or what nursing tasks needed to be completed.

F 0333

Make sure that residents are safe from serious medication errors.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure residents were free of significant medication errors for one of twenty-nine sampled residents (Resident #9). On 03/28/13 at 4:00 PM, the facility failed to administer Resident #9's physician ordered insulin. The findings include: A review of the facility policy, Medication Administration-Administering Medications, dated December 2010, revealed medications were to be administered only as ordered by a physician. Staff was to chart on the medication sheet and/or nurse's notes any failure to administer medication, regardless of the reason. The facility admitted Resident #9 on 11/30/12, with [DIAGNOSES REDACTED]. A review of Resident #9's Quarterly Minimum Data Set (MDS) assessment completed on 03/04/13 revealed the facility assessed the resident to have a cognitive summary score of 13 and to require supervision/limited assistance for all activities of daily living. A review of Resident #9's Comprehensive Care Plan dated 03/04/13, revealed a problem of uncontrolled Diabetes, and the resident was to receive medications as ordered by the physician. Review of Resident #9's physician's orders dated March 2013 revealed staff was to administer to Resident #9 30 units of [MEDICATION NAME] 70/30 insulin every evening at 4:00 PM. Review of Resident #9's Treatment Administration Record (TAR) at 6:15 PM revealed the resident had not been administered the insulin as ordered. Observation of Resident #9 on 03/29/13 at 3:12 PM, revealed the resident to be sitting up on the bed. Resident #1 denied any problems related to the insulin not being administered as ordered on [DATE]. Interview with the Staff Development Coordinator (SDC) at 8:05 PM on 03/28/13, revealed she was told by Administration sometime after 4:00 PM (exact time unknown) to cover the Seasons Unit, related to the assigned nurse being removed from direct patient care. The SDC stated that she received no report prior to being assigned to care for the residents and had no communication with the prior nurse. The SDC stated she was unaware that Accuchecks had not been obtained for residents on the Seasons Unit. Interview with Administrator #2 on 03/28/13 at 8:00 PM confirmed the nurse assigned to the Seasons Unit was removed from direct patient care after an allegation of abuse was made. Administrator #2 stated the SDC was assigned to cover the floor but Administrator #2 had made no provisions to ensure the continuity of resident care, such as ensuring the SDC received a detailed report of what care needs the residents required, or what nursing tasks needed to be completed.

F 0371

Store, cook, and serve food in a safe and clean way.

Based on observation and interview, it was determined the facility failed to store food under sanitary conditions. Two ingredient storage bins were observed not to close tightly and as a result, the facility could not ensure the contents of the storage bins were free from contamination. In addition, one of the storage bins, reported to contain flour, was not labeled. The findings include: The sanitation tour in the kitchen was conducted at 9:20 AM on 04/04/13. During the tour, two ingredient storage bins were observed to be damaged and, as a result, the lids would not completely close which exposed the ingredients to possible contamination. One of the storage bins reportedly contained loose flour (out of the original container) and was not labeled with the name of the contents. The other storage bin contained a variety of pasta; however, the bin was unlabeled. An interview was conducted with the Dietary Manager (DM) at 9:30 AM on 04/04/13. The DM confirmed the lids on the two storage bins did not fit properly, were not airtight, and as a result, the contents of the bins could be exposed to possible contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0371	(continued... from page 36)
F 0371	**Store, cook, and serve food in a safe and clean way.** Based on observation and interview, it was determined the facility failed to store food under sanitary conditions. Two ingredient storage bins were observed not to close tightly and as a result, the facility could not ensure the contents of the storage bins were free from contamination. In addition, one of the storage bins, reported to contain flour, was not labeled. The findings include: The sanitation tour in the kitchen was conducted at 9:20 AM on 04/04/13. During the tour, two ingredient storage bins were observed to be damaged and, as a result, the lids would not completely close which exposed the ingredients to possible contamination. One of the storage bins reportedly contained loose flour (out of the original container) and was not labeled with the name of the contents. The other storage bin contained a variety of pasta; however, the bin was unlabeled. An interview was conducted with the Dietary Manager (DM) at 9:30 AM on 04/04/13. The DM confirmed the lids on the two storage bins did not fit properly, were not airtight, and as a result, the contents of the bins could be exposed to possible contamination.
F 0425	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to ensure the accurate acquiring, receiving, and administering of all drugs and biologicals to meet the needs of two of twenty-nine sampled residents (Residents #3 and #9) and one unsampled resident (Resident D). The facility failed to follow accepted standards of practice regarding the administration of medications via enteral feeding tubes which placed residents with feeding tubes for receiving nourishment and oral medications at risk of experiencing occluded feeding tubes (Resident D). In addition, the facility failed to follow its policy related to use of the facility's Emergency Medication Kit, and failed to monitor and account for all medications removed from the kit (Residents #3 and #9). The findings include: 1. Resident D received nourishment and oral medications via a feeding tube. During the morning medication pass on 04/02/13 at 9:30 AM, the resident was to receive six oral dosage forms which included four tablet dosage forms (Aspirin 81 mg, Namenda 10 mg, Zantac 150 mg, and a Multivitamin with Minerals). During the preparation of the medications, LPN #4 was observed to crush the four tablets, and then mix the resultant powders in a dose cup. During the administration procedure, the nurse checked the placement of the resident's tube, checked the tube's residual, and then performed an initial flush of the tube with approximately 30 milliliters (ml) of water. The nurse then separately administered two liquid dosage forms (the liquid contents of two fish oil capsules and 2.5 ml of Valproic Acid Syrup), both diluted with a small portion of water. The nurse then administered the mixture of the crushed tablets mixed with a small amount of water (approximately 30 ml) followed by a liberal post-flush with more water. Before leaving the room, the nurse concluded the care by administering a bolus feeding consisting of a can of Jevity 1.2. Following the medication pass observation, review of Resident D's clinical record revealed no evidence of a physician's orders [REDACTED]. A review of the facility's policy related to administration of medications via feeding tube (Policy #7.10, titled Enteral Tubes, dated December 2012) revealed Item #10 of the policy stated, Medication administration and flushing of the tube after each individual medication is given if required if there are known compatibility problems between the medications to be mixed together. A minimum of one flush before and after giving the medications was acceptable unless there is a physician's orders [REDACTED]. However, medications should be administered separately with a flush between medications. Interview on 04/02/13 at 5:00 PM, with LPN #4 revealed she administered the medications via feeding tube to Resident D that morning in accordance with facility policy, but noted having been told by other staff following the morning medication pass that the current acceptable standard was now to administer the medications separately using flushes between all medications unless otherwise directed by the physician. 2. On 03/28/13 at approximately 2:00 PM, while reviewing the Medication Administration Records (MARs) for residents living on the Seasons Unit, Resident #9 was noted to have received a 10-day regimen of the antibiotic Macrobid 100 mg (one capsule twice daily) for a urinary tract infection. The drug was scheduled for administration at 9:00 AM and 9:00 PM, and the MAR (Medication Administration Record) revealed the resident's therapy began on 03/16/13 at 9:00 AM and concluded on 03/25/13 at 9:00 AM, and that all 20 ordered doses were given as ordered. Review of the resident's orders revealed the Macrobid order was posted on 03/15/13, and dispensing records revealed that 20 capsules were delivered from the pharmacy on 03/16/13. The time of delivery would have been at approximately 11:00 PM, indicating the resident's initial two doses were obtained from a source other than the actual prescription. At 3:00 PM on 03/28/13, the Seasons Unit medication cart was audited and revealed that Resident #9's drawer contained the package of Macrobid 100 mg dispensed by the pharmacy on 03/15/13 for 20 capsules, and although the therapy concluded on 03/25/13, the container revealed the presence of 12 capsules, indicating the resident may have failed to receive up to 12 of the 20 ordered doses. Interview at 6:30 PM on 03/28/13, with KMA #3 concerning Resident #9's extra antibiotics revealed KMA #3 was unable to explain why the 12 capsules remained in the drawer, and stated it was very common to initiate a new medication order through use of the facility's E-Box or in some cases by ordering a 24-hour supply from their backup pharmacy (Rite-Aid). During the course of the interview, the unit's E-Box was inspected, showing that it was authorized to contain 4 capsules of Macrobid 100 mg. The aide explained that when removing a medication from the E-Box staff was expected to fill out a dual copy usage report, with the top (white) copy being placed inside the current E-Box for receipt by the pharmacy and the second (yellow) copy to be placed in a receipt box (located near the E-Box) to be forwarded to the Medical Records Department. Although the box contained some yellow copies from previous transactions, there were no copies found related to any Macrobid obtained for Resident #9. On 04/03/13 at approximately 10:00 AM, the issue of the E-Boxes was discussed with Administrator #2, the Acting Director of Nursing (DON), and the CNE (Chief Nurse Executive). They reported they were unable to locate any proof (e.g., usage reports) that any doses of Macrobid had ever been obtained from the E-Box for Resident #9. On 04/03/13 at 2:40 PM, during an interview with the Director of the provider pharmacy, the Director estimated that staff usually failed to fill out and forward usage reports in the E-Box about 50 percent of the time. He also stated that in most instances any usage reports placed inside the E-Box would be discarded since they were not used for billing purposes. He further explained that a daily per diem the pharmacy received from the facility would cover payment of most items taken from the E-Boxes. The Director explained he was unaware of any complaints regarding the facility's use of the E-Boxes, or complaints regarding residents not being given their medications as ordered. The Director explained it would be impossible to determine why Resident #9 continued to have the 12 capsules of Macrobid in her drawer. However, he did speculate that, because most of their unit-dose pills were packed in strips of 30 pills, it was possible a pharmacy tech could have placed a full strip of 30 pills in Resident #9's box instead of the ordered 20 capsules. Since the resident's first two doses of the Macrobid could have likely come from the E-Box, he commented that could explain the presence of the 12 capsules. As a result of an on-site visit to the facility's backup pharmacy on 04/04/13, it was determined that Resident #9 had no prescription activity over the previous 90 days and the 12 extra doses of Macrobid could not be traced to a prescription at the backup pharmacy. 3. During the review on 03/28/13 of the MARs for the residents living on the Seasons Unit, Resident #3 was noted to have been treated with a 10-day course of the antibiotic, Clindamycin 150 mg (one capsule 3 times daily for 10 days) which was initiated at 9:00 AM on 03/14/13 and concluded at 9:00 PM on 03/23/13. The MAR indicated [REDACTED]. The resident's clinical record revealed the order was given by the physician on 03/14/13, and review of the pharmacy's shipping manifest revealed the medication was delivered to the facility on [DATE] (toward the end of the day). At least the first three doses would have been obtained from a source other than the prescription order. However, inspection of the resident's medication drawer revealed the prescription box was still present in the drawer, that the package was labeled as having contained 30 capsules, was dispensed on 03/14/13, and still contained 5 capsules, even though the duration of therapy had concluded on 03/23/13, thereby indicating the resident could have failed to receive up to 5 of 30 ordered doses. Interview on 03/28/13, with KMA #3 revealed the resident's five extra capsules of Clindamycin probably came from the E-Box. Interview on 04/03/13 at approximately 10:00 AM with the Acting DON and the CNE revealed they were unable to obtain evidence that staff had obtained any doses of Clindamycin for Resident #3 from the E-Box. Review of records at the facility's backup pharmacy revealed no Clindamycin had been provided to Resident #3. Review of the facility's policy related to use of the E-Box (Policy #3.4, Emergency Pharmacy Service and Emergency Kits) revealed that staff did not consistently follow the policy. For example: A) Item #8 of the policy stated that upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on the emergency kit log. One copy of this information should be

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0425

(continued... from page 37)
immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. B) Item #9 stated that use of emergency medications was to be noted on the resident's current MAR. However, that was not done as evidenced by the March MARs for Residents #3 and #9.

F 0425

Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review, it was determined that the facility failed to ensure the accurate acquiring, receiving, and administering of all drugs and biologicals to meet the needs of two of twenty-nine sampled residents (Residents #3 and #9) and one unsampled resident (Resident D). The facility failed to follow accepted standards of practice regarding the administration of medications via enteral feeding tubes which placed residents with feeding tubes for receiving nourishment and oral medications at risk of experiencing occluded feeding tubes (Resident D). In addition, the facility failed to follow its policy related to use of the facility's Emergency Medication Kit, and failed to monitor and account for all medications removed from the kit (Residents #3 and #9). The findings include: 1. Resident D received nourishment and oral medications via a feeding tube. During the morning medication pass on 04/02/13 at 9:30 AM, the resident was to receive six oral dosage forms which included four tablet dosage forms (Aspirin 81 mg, Namenda 10 mg, Zantac 150 mg, and a Multivitamin with Minerals). During the preparation of the medications, LPN #4 was observed to crush the four tablets, and then mix the resultant powders in a dose cup. During the administration procedure, the nurse checked the placement of the resident's tube, checked the tube's residual, and then performed an initial flush of the tube with approximately 30 milliliters (ml) of water. The nurse then separately administered two liquid dosage forms (the liquid contents of two fish oil capsules and 2.5 ml of Valproic Acid Syrup), both diluted with a small portion of water. The nurse then administered the mixture of the crushed tablets mixed with a small amount of water (approximately 30 ml) followed by a liberal post-flush with more water. Before leaving the room, the nurse concluded the care by administering a bolus feeding consisting of a can of Jevity 1.2. Following the medication pass observation, review of Resident D's clinical record revealed no evidence of a physician's orders [REDACTED]. A review of the facility's policy related to administration of medications via feeding tube (Policy #7.10, titled Enteral Tubes, dated December 2012) revealed Item #10 of the policy stated, Medication administration and flushing of the tube after each individual medication is given if required if there are known compatibility problems between the medications to be mixed together. A minimum of one flush before and after giving the medications was acceptable unless there is a physician's orders [REDACTED]. However, medications should be administered separately with a flush between medications. Interview on 04/02/13 at 5:00 PM, with LPN #4 revealed she administered the medications via feeding tube to Resident D that morning in accordance with facility policy, but noted having been told by other staff following the morning medication pass that the current acceptable standard was now to administer the medications separately using flushes between all medications unless otherwise directed by the physician. 2. On 03/28/13 at approximately 2:00 PM, while reviewing the Medication Administration Records (MARs) for residents living on the Seasons Unit, Resident #9 was noted to have received a 10-day regimen of the antibiotic Macrobid 100 mg (one capsule twice daily) for a urinary tract infection. The drug was scheduled for administration at 9:00 AM and 9:00 PM, and the MAR (Medication Administration Record) revealed the resident's therapy began on 03/16/13 at 9:00 AM and concluded on 03/25/13 at 9:00 AM, and that all 20 ordered doses were given as ordered. Review of the resident's orders revealed the Macrobid order was posted on 03/15/13, and dispensing records revealed that 20 capsules were delivered from the pharmacy on 03/16/13. The time of delivery would have been at approximately 11:00 PM, indicating the resident's initial two doses were obtained from a source other than the actual prescription. At 3:00 PM on 03/28/13, the Seasons Unit medication cart was audited and revealed that Resident #9's drawer contained the package of Macrobid 100 mg dispensed by the pharmacy on 03/15/13 for 20 capsules, and although the therapy concluded on 03/25/13, the container revealed the presence of 12 capsules, indicating the resident may have failed to receive up to 12 of the 20 ordered doses. Interview at 6:30 PM on 03/28/13, with KMA #3 concerning Resident #9's extra antibiotics revealed KMA #3 was unable to explain why the 12 capsules remained in the drawer, and stated it was very common to initiate a new medication order through use of the facility's E-Box or in some cases by ordering a 24-hour supply from their backup pharmacy (Rite-Aid). During the course of the interview, the unit's E-Box was inspected, showing that it was authorized to contain 4 capsules of Macrobid 100 mg. The aide explained that when removing a medication from the E-Box staff was expected to fill out a dual copy usage report, with the top (white) copy being placed inside the current E-Box for receipt by the pharmacy and the second (yellow) copy to be placed in a receipt box (located near the E-Box) to be forwarded to the Medical Records Department. Although the box contained some yellow copies from previous transactions, there were no copies found related to any Macrobid obtained for Resident #9. On 04/03/13 at approximately 10:00 AM, the issue of the E-Boxes was discussed with Administrator #2, the Acting Director of Nursing (DON), and the CNE (Chief Nurse Executive). They reported they were unable to locate any proof (e.g., usage reports) that any doses of Macrobid had ever been obtained from the E-Box for Resident #9. On 04/03/13 at 2:40 PM, during an interview with the Director of the provider pharmacy, the Director estimated that staff usually failed to fill out and forward usage reports in the E-Box about 50 percent of the time. He also stated that in most instances any usage reports placed inside the E-Box would be discarded since they were not used for billing purposes. He further explained that a daily per diem the pharmacy received from the facility would cover payment of most items taken from the E-Boxes. The Director explained he was unaware of any complaints regarding the facility's use of the E-Boxes, or complaints regarding residents not being given their medications as ordered. The Director explained it would be impossible to determine why Resident #9 continued to have the 12 capsules of Macrobid in her drawer. However, he did speculate that, because most of their unit-dose pills were packed in strips of 30 pills, it was possible a pharmacy tech could have placed a full strip of 30 pills in Resident #9's box instead of the ordered 20 capsules. Since the resident's first two doses of the Macrobid could have likely come from the E-Box, he commented that could explain the presence of the 12 capsules. As a result of an on-site visit to the facility's backup pharmacy on 04/04/13, it was determined that Resident #9 had no prescription activity over the previous 90 days and the 12 extra doses of Macrobid could not be traced to a prescription at the backup pharmacy. 3. During the review on 03/28/13 of the MARs for the residents living on the Seasons Unit, Resident #3 was noted to have been treated with a 10-day course of the antibiotic, Clindamycin 150 mg (one capsule 3 times daily for 10 days) which was initiated at 9:00 AM on 03/14/13 and concluded at 9:00 PM on 03/23/13. The MAR indicated [REDACTED]. The resident's clinical record revealed the order was given by the physician on 03/14/13, and review of the pharmacy's shipping manifest revealed the medication was delivered to the facility on [DATE] (toward the end of the day). At least the first three doses would have been obtained from a source other than the prescription order. However, inspection of the resident's medication drawer revealed the prescription box was still present in the drawer, that the package was labeled as having contained 30 capsules, was dispensed on 03/14/13, and still contained 5 capsules, even though the duration of therapy had concluded on 03/23/13, thereby indicating the resident could have failed to receive up to 5 of 30 ordered doses. Interview on 03/28/13, with KMA #3 revealed the resident's five extra capsules of Clindamycin probably came from the E-Box. Interview on 04/03/13 at approximately 10:00 AM with the Acting DON and the CNE revealed they were unable to obtain evidence that staff had obtained any doses of Clindamycin for Resident #3 from the E-Box. Review of records at the facility's backup pharmacy revealed no Clindamycin had been provided to Resident #3. Review of the facility's policy related to use of the E-Box (Policy #3.4, Emergency Pharmacy Service and Emergency Kits) revealed that staff did not consistently follow the policy. For example: A) Item #8 of the policy stated that upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on the emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. B) Item #9 stated that use of emergency medications was to be noted on the resident's current MAR. However, that was not done as evidenced by the March MARs for Residents #3 and #9.

F 0431

Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.

Based on observation, interview, and record review, it was determined that the facility failed to store medications and

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	185337	A. BUILDING ______ B. WING _____	**04/09/2013**

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F 0431

(continued... from page 38)

biologicals under acceptable temperature parameters. It was determined that staff on Units B and C was storing unopened vials of insulin inside treatment carts and not under refrigeration per facility policy and in accordance with professional standards of practice. The findings include: Review of the of the facility's policy related to medication storage (Policy #4.1, Storage of Medications) revealed the storage of insulin, Item #12 instructed staff that Insulin products should be stored in the refrigerator until opened. The opened insulin vial may be stored in the refrigerator or at room temperature. Opened insulin pens must be stored at room temperature. Although not specified in the facility policy, the provider pharmacy instructed staff through its labeling of insulin vials that, upon opening new vials of insulin, staff was to note the date of opening on either the bottle or outer box of the insulin, and then store it at room temperature and discard/replace any unused portion of the insulin after 28 days of opening. Observation on 04/04/13 at 11:00 AM, of the Seasons Unit Medication Room revealed several unopened vials of insulin stored in the unit refrigerator. Interview with Registered Nurse (RN) #7 revealed that opened vials of insulin were stored in the unit's treatment cart, at room temperature. Inspection of the treatment cart revealed the presence of several opened vials of insulin, all noted with the date of opening, and all determined to be within the 28-day timeframe and were appropriate for continued use. RN #7 stated it was the facility's policy to refrigerate the vials prior to use, to date them upon opening and store unrefrigerated, and then use the insulin for up to 28 days of opening. Observation on 04/04/13 at 1:30 PM, of the B Unit Medication Room medication refrigerator revealed no vials of insulin. During an interview with RN #6, she stated she was not sure of the facility's policy regarding insulin storage, but stated that it was the procedure on the B Unit to place vials of insulin in the treatment cart immediately upon delivery from the pharmacy. The nurse admitted the procedure used on the B Unit did vary from the one used on the Seasons Unit. Inspection of the treatment cart on the B Unit revealed several opened vials of insulin, most having been recently dispensed by the pharmacy, and with opening dates noted on the bottle or the exterior box; all were determined to be within the 28-day timeframe for continued usage. However, Resident #13 was noted to have an unopened vial of NovoLog Insulin which had been dispensed on 01/19/13 as well as another unopened vial of the same, dispensed on 03/05/13. Based on observation and the nurse's interview, it was determined both unopened vials had been stored outside of refrigeration for 28 or more days, and were unacceptable for resident use per the facility policy. At 2:00 PM on 04/04/13, the C Unit Medication Room was inspected. RN #4 stated it was Unit C's practice to place all insulin delivered by the pharmacy immediately in the treatment carts instead of the refrigerator. Observation of the unit's refrigerator revealed no storage of insulin of any kind. However, inspection of the treatment carts revealed the storage of numerous open vials of insulin, the majority having been recently dispensed by the pharmacy, all with noted opening dates, and all within the 28-day timeframe for acceptable use. However, six unopened vials of insulin were also observed which, based on the nurse interview, had been stored outside of refrigeration for 28 or more days, and were unacceptable for use. The vials included four unopened vials of NovoLog Insulin assigned to Resident A (two vials dispensed on 02/03/13 and two vials dispensed on 03/03/13). In addition, Resident B had an unopened vial of Lantus Insulin (dispensed on 03/06/13) and an unopened vial of NovoLog Insulin (dispensed on 02/27/13). Interview with the facility's Consultant Pharmacist at approximately 2:45 PM on 04/04/13 revealed staff should be storing unopened insulin in the refrigerator prior to using, etc. The pharmacist stated he would follow up regarding the use and storage of insulin. He further stated he planned to provide staff in-servicing on the issue. Further interview on 04/05/13 at 1:30 PM, with the Consultant Pharmacist revealed he had placed the majority of the C Unit's unopened insulin (found on the previous day) in the refrigerator. At approximately 2:00 PM, an inspection of the C Unit refrigerator revealed that about 12-15 unopened vials of insulin were now under storage in the refrigerator. However, the six vials earlier noted (involving Residents A and B) were among those stored in the refrigerator. As earlier noted, all of those vials had been previously stored at room temperature for 28 or more days, so their potencies could not be ensured.

F 0431

Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.

Based on observation, interview, and record review, it was determined that the facility failed to store medications and biologicals under acceptable temperature parameters. It was determined that staff on Units B and C was storing unopened vials of insulin inside treatment carts and not under refrigeration per facility policy and in accordance with professional standards of practice. The findings include: Review of the of the facility's policy related to medication storage (Policy #4.1, Storage of Medications) revealed the storage of insulin, Item #12 instructed staff that Insulin products should be stored in the refrigerator until opened. The opened insulin vial may be stored in the refrigerator or at room temperature. Opened insulin pens must be stored at room temperature. Although not specified in the facility policy, the provider pharmacy instructed staff through its labeling of insulin vials that, upon opening new vials of insulin, staff was to note the date of opening on either the bottle or outer box of the insulin, and then store it at room temperature and discard/replace any unused portion of the insulin after 28 days of opening. Observation on 04/04/13 at 11:00 AM, of the Seasons Unit Medication Room revealed several unopened vials of insulin stored in the unit refrigerator. Interview with Registered Nurse (RN) #7 revealed that opened vials of insulin were stored in the unit's treatment cart, at room temperature. Inspection of the treatment cart revealed the presence of several opened vials of insulin, all noted with the date of opening, and all determined to be within the 28-day timeframe and were appropriate for continued use. RN #7 stated it was the facility's policy to refrigerate the vials prior to use, to date them upon opening and store unrefrigerated, and then use the insulin for up to 28 days of opening. Observation on 04/04/13 at 1:30 PM, of the B Unit Medication Room medication refrigerator revealed no vials of insulin. During an interview with RN #6, she stated she was not sure of the facility's policy regarding insulin storage, but stated that it was the procedure on the B Unit to place vials of insulin in the treatment cart immediately upon delivery from the pharmacy. The nurse admitted the procedure used on the B Unit did vary from the one used on the Seasons Unit. Inspection of the treatment cart on the B Unit revealed several opened vials of insulin, most having been recently dispensed by the pharmacy, and with opening dates noted on the bottle or the exterior box; all were determined to be within the 28-day timeframe for continued usage. However, Resident #13 was noted to have an unopened vial of NovoLog Insulin which had been dispensed on 01/19/13 as well as another unopened vial of the same, dispensed on 03/05/13. Based on observation and the nurse's interview, it was determined both unopened vials had been stored outside of refrigeration for 28 or more days, and were unacceptable for resident use per the facility policy. At 2:00 PM on 04/04/13, the C Unit Medication Room was inspected. RN #4 stated it was Unit C's practice to place all insulin delivered by the pharmacy immediately in the treatment carts instead of the refrigerator. Observation of the unit's refrigerator revealed no storage of insulin of any kind. However, inspection of the treatment carts revealed the storage of numerous open vials of insulin, the majority having been recently dispensed by the pharmacy, all with noted opening dates, and all within the 28-day timeframe for acceptable use. However, six unopened vials of insulin were also observed which, based on the nurse interview, had been stored outside of refrigeration for 28 or more days, and were unacceptable for use. The vials included four unopened vials of NovoLog Insulin assigned to Resident A (two vials dispensed on 02/03/13 and two vials dispensed on 03/03/13). In addition, Resident B had an unopened vial of Lantus Insulin (dispensed on 03/06/13) and an unopened vial of NovoLog Insulin (dispensed on 02/27/13). Interview with the facility's Consultant Pharmacist at approximately 2:45 PM on 04/04/13 revealed staff should be storing unopened insulin in the refrigerator prior to using, etc. The pharmacist stated he would follow up regarding the use and storage of insulin. He further stated he planned to provide staff in-servicing on the issue. Further interview on 04/05/13 at 1:30 PM, with the Consultant Pharmacist revealed he had placed the majority of the C Unit's unopened insulin (found on the previous day) in the refrigerator. At approximately 2:00 PM, an inspection of the C Unit refrigerator revealed that about 12-15 unopened vials of insulin were now under storage in the refrigerator. However, the six vials earlier noted (involving Residents A and B) were among those stored in the refrigerator. As earlier noted, all of those vials had been previously stored at room temperature for 28 or more days, so their potencies could not be ensured.

F 0469

Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0469

(continued... from page 39)
Based on observation, interview, and record review it was determined the facility failed to have an effective pest control program to ensure the facility was free of pests. Ants were observed in resident rooms A-1, A-2, and A-6 on 04/02/13 and 04/03/13. The findings include: A review of the facility pest control contract dated 11/01/06 revealed a pest control company would provide structural pest control services as need to effectively control ants. Further review of the contract revealed treatment for [REDACTED]. Observations of resident rooms conducted during environmental tours on 04/02/13 at 4:00 PM and on 04/03/13 at 10:05 AM revealed small black ants, too numerous to count, in resident rooms A-1, A-2, and A-6 near windowsills and baseboards. A review of monthly pest control invoices dated 02/15/13 and 03/27/13 revealed no evidence the interior of the building had been treated for [REDACTED]. A review of a deep cleaning schedule for room A-1 revealed ants were reported to Maintenance on 03/29/13 when the room had been cleaned by Housekeeping. An interview conducted with the Housekeeping Supervisor on 04/03/13 at 5:15 PM, revealed resident rooms were cleaned daily by Housekeeping and were deep cleaned once per month. Further interview revealed the Housekeeping Supervisor was not aware that ants were still present in resident rooms A-1, A-2, and A-6. An interview with the Maintenance Director on 04/03/13 at 5:30 PM, revealed the Maintenance Director had treated rooms A-1 and A-6 for ants on 03/29/13, but was not aware the ants were still in the resident rooms. Additional interview revealed the Maintenance Director had not treated room A-2 nor was he aware there were ants in the room. According to the Maintenance Director, he toured monthly to identify concerns and toured with the pest control company's representative when the interior of the facility was treated monthly. The Maintenance Director stated that he had not contacted the pest control company regarding the ants because he had ant bait to treat for the ants.

F 0469

Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, and record review it was determined the facility failed to have an effective pest control program to ensure the facility was free of pests. Ants were observed in resident rooms A-1, A-2, and A-6 on 04/02/13 and 04/03/13. The findings include: A review of the facility pest control contract dated 11/01/06 revealed a pest control company would provide structural pest control services as need to effectively control ants. Further review of the contract revealed treatment for [REDACTED]. Observations of resident rooms conducted during environmental tours on 04/02/13 at 4:00 PM and on 04/03/13 at 10:05 AM revealed small black ants, too numerous to count, in resident rooms A-1, A-2, and A-6 near windowsills and baseboards. A review of monthly pest control invoices dated 02/15/13 and 03/27/13 revealed no evidence the interior of the building had been treated for [REDACTED]. A review of a deep cleaning schedule for room A-1 revealed ants were reported to Maintenance on 03/29/13 when the room had been cleaned by Housekeeping. An interview conducted with the Housekeeping Supervisor on 04/03/13 at 5:15 PM, revealed resident rooms were cleaned daily by Housekeeping and were deep cleaned once per month. Further interview revealed the Housekeeping Supervisor was not aware that ants were still present in resident rooms A-1, A-2, and A-6. An interview with the Maintenance Director on 04/03/13 at 5:30 PM, revealed the Maintenance Director had treated rooms A-1 and A-6 for ants on 03/29/13, but was not aware the ants were still in the resident rooms. Additional interview revealed the Maintenance Director had not treated room A-2 nor was he aware there were ants in the room. According to the Maintenance Director, he toured monthly to identify concerns and toured with the pest control company's representative when the interior of the facility was treated monthly. The Maintenance Director stated that he had not contacted the pest control company regarding the ants because he had ant bait to treat for the ants.

F 0490

Be administered in an acceptable way that maintains the well-being of each resident .

Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to be administered in a manner that maintained the highest physical well-being for six of twenty-nine sampled residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure staff immediately reported allegations of abuse to Administration and to the appropriate State Agencies; failed to ensure all residents were protected from abuse during facility investigations; and failed to ensure thorough investigations had been conducted related to abuse allegations. (Refer to F223, F225, F226, and F520.) The Administration's failure to ensure facility policies/procedures related to abuse prevention were developed and implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated, Any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, Any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 1. Interview and review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying, wanting to go to bed. Staff reported LPN #1, the Charge Nurse, would not allow staff to assist the resident to bed due to the resident yelling, whining, and crying. One staff member reported LPN #1 made the comment that she was going to teach the resident a lesson. Interviews revealed staff did not immediately take action to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, and LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse had occurred). Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. During the facility's investigation, LPN #1 was interviewed and stated she wanted Resident #1 to stay at the nurses' station to be monitored for the resident's behavior. Facility staff interviewed other residents on the unit and one other resident reported he/she had overheard the LPN say negative things about another resident. The investigation further stated based on the investigation abuse could not be substantiated. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. Administrator #1 acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson and he was aware an alert and oriented resident had reported witnessing LPN #1 be inappropriate and rude to another resident previously. However, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1. Therefore, the allegation of abuse was unsubstantiated, and no further disciplinary action was taken against the LPN concerning the alleged abuse to Resident #1. However, review of the facility's policy revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and

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LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490	(continued... from page 40) grievances presented to them. Further interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility's policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, the policy stated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 2. A review of the facility's first AOC, alleging removal of jeopardy on 03/06/13, revealed all staff, including the Administrator, the DON, Social Worker/Abuse Coordinator were re-educated beginning 03/04/13, on the revisions of the abuse policy. The AOC further stated that the Chief Nurse Executive reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's Social Worker/Abuse Coordinator approximately two to three months prior when the incident occurred. Resident #29 alleged that a male staff member touched her breast inappropriately and the resident was afraid of the staff person. An interview with the Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM revealed the allegation was not reported to the appropriate State Agencies and the alleged perpetrator continued to provide direct care because the facility felt it was not abuse, even though a complete investigation had not been conducted. There was no evidence the facility identified as part of their review of past investigations as stated in the AOC that this investigation was not thorough, the abuse allegation was not reported, and the resident was not protected. Administrator #1, who was the Administrator on record during this time, was no longer employed as Administrator of the facility and was not available for interview. Interview on 04/05/13 at 6:05 PM, with the Vice President of Operations who was also acting as the facility's Administrator, revealed he was not aware of the incident involving Resident #29. However, further interview on 04/05/13 at 7:30 PM, revealed he did recall Administrator #1 telling him about the incident; however, he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. Interview and review of the facility's investigation dated 04/01/13 revealed on 03/27/13 the Administrator was notified of an allegation of abuse involving RN #8 and Resident #4 that occurred on 03/24/13. A review of a facility's investigation dated 04/01/13, revealed on 03/24/13, Resident #4 alleged RN #8 was mean to the resident and the resident did not want RN #8 to provide further care for the resident and did not want RN #8 to come back to Resident #4's room. The facility interviewed Resident #4, the RN, and all residents with a Brief Interview for Mental Status (BIMS) score of 8 or higher. Based on this information, the facility unsubstantiated that abuse occurred based on Resident #4's moderately impaired cognitive ability. Interview with the DON on 04/02/13 at 8:45 PM revealed she became aware of the allegation on 03/24/13; however, did not notify the Administrator, or initiate an investigation until 03/27/13, three days later, when the Corporate Nurse Consultant questioned her regarding the incident. Interview with Administrator #2 on 03/28/13 at 2:00 PM, 6:40 PM, and on 03/29/13 at 10:25 AM, and 4:11 PM revealed he became aware of the incident on 03/27/13 around 5:40 PM. Administrator #2 stated the DON informed him she had forgotten to start an investigation related to the incident and forgot to inform him of the allegation of abuse. Further interview revealed Administrator #2 did not think it was reportable. He stated, In my heart of hearts I have gotten to know the little girl while I've been here. I just didn't feel it was true and reportable, even before the investigation had been complete. 4. A review of the facility's second AOC, dated 04/05/13, alleging removal of jeopardy on 04/05/13, revealed facility staff, including the facility Administrator, DON, and Social Worker/Abuse Coordinator, had been retrained on abuse protocols that included investigation, reporting, and protection of residents. In addition, according to the AOC, an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, interview with the facility's Social Worker/Abuse Coordinator on 04/09/13 revealed four other allegations of resident abuse involving Residents #19, #29, #30, and #31 had been reported to facility staff and there was no evidence the abuse allegations had been reported to the appropriate State Agencies, had been thoroughly investigated, or that facility residents had been protected from further potential abuse. In addition, review of the facility's abuse log revealed no entry for the abuse allegations involving Residents #19, #29, #30, and #31. An interview with Administrator #2 on 04/09/13 at 5:45 PM, revealed the abuse log was not effective to identify facility failures to investigate, report, and protect Residents #19, #29, #30, and #31 when an allegation was reported. Administrator #2 stated he was not aware of these allegations of abuse. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. The Administrator of record during the time of the alleged abuse allegations, Administrator #1, has been suspended by the Chief Operating Officer on 04/05/13. An investigation has been initiated. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a post-test. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ---Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, and a review of a statement written by the Chief Operating Officer dated 04/22/13 revealed he suspended the Administrator of record on 04/05/13, Administrator #1. Interview with on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 1:46 PM with the Clinical Regional Nurse Consultant; at 2:12 PM with the Chief Operating Officer; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 12:57 PM with the Central Supply and Staffing Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; at 1:23 PM with the Staff Development Coordinator; and at 1:40 PM with the Director of Maintenance confirmed they had received training on abuse by the Independent Contractor on 04/06/13 and had completed a post test. The above Regional Staff and Department Directors verified they had also assisted with education of the remaining staff on 04/12/13. Review of post-test and interviews on 04/23/13 at 10:35 AM with State Registered Nurse Aide (SRNA) #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:05 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #9; at 12:38 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:56 PM with Certified

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F 0490

(continued... from page 41)
Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 confirmed they were re-educated by Department Directors and/or Regional Staff. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the DON; and at 12:38 PM with the Interim Social Services Director revealed the Independent Contractor did provide them with one on one education related to protection, reporting, and investigation of allegations of abuse prior to 04/12/13. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis.

---During a complaint investigation (KY) conducted in conjunction with the revisit, an additional example of noncompliance was identified. Interview, review of the facility investigation and review of the facility's Abuse, Neglect and Misappropriation Policy, revealed the facility failed to be administered in a manner that maintained the highest physical well-being for Resident #32. The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure allegations of abuse were reported to the State Survey Agency in a timely manner. (Refer to F225 and F226.) A review of the facility's Abuse, Neglect and Misappropriation policy, revised March 2013 and effective April 2013, revealed, all allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with officials in accordance with State law through established guidelines. A review of the facility's investigation report revealed on 04/17/13, at approximately 10:50 AM, Licensed Practical Nurse (LPN) #5 reported to the facility's Administration that Kentucky Medication Aide (KMA) #6 reported an allegation that had been made against her (KMA #6). According to the facility's investigation, while KMA #6 was providing care to Resident #32 that morning (04/17/13), the resident told KMA #6 that she was pulling the resident's hair and trying to kill the resident. According to documentation on the report, the alleged perpetrator (KMA #6) was immediately suspended and an investigation was initiated. The report further revealed the allegation was reported to the State Survey Agency on 04/18/13 at 5:52 PM (a timeframe of 31 hours after the allegation had been reported to the administration of the facility). Interview on 04/22/13 at 2:15 PM with the Chief Nurse Executive (CNE) revealed the regulatory guidelines indicated reporting of an allegation of abuse ought not to exceed 24 hours, and had interpreted the statement to mean the facility could have more time to report if necessary. The interview further revealed the CNE thought the time frame was in business hours and the facility was a 24-hour business. Administrator #2 acknowledged in interview on 04/22/13 at 1:58 PM that the facility had not reported the incident until 04/18/13 at 5:52 PM even though the facility staff had reported the incident to Administration at approximately 10:50 AM on 04/17/13. According to the Administrator, he thought the facility had until midnight the day after an incident had been reported to make the report and stated he thought the 24-hour timeframe was from midnight on the day the incident occurred to midnight the day after the incident occurred.

F 0490

Be administered in an acceptable way that maintains the well-being of each resident .

Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to be administered in a manner that maintained the highest physical well-being for six of twenty-nine sampled residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure staff immediately reported allegations of abuse to Administration and to the appropriate State Agencies; failed to ensure all residents were protected from abuse during facility investigations; and failed to ensure thorough investigations had been conducted related to abuse allegations. (Refer to F223, F225, F226, and F520.) The Administration's failure to ensure facility policies/procedures related to abuse prevention were developed and implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated, Any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, Any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 1. Interview and review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying, wanting to go to bed. Staff reported LPN #1, the Charge Nurse, would not allow staff to assist the resident to bed due to the resident yelling, whining, and crying. One staff member reported LPN #1 made the comment that she was going to teach the resident a lesson. Interviews revealed staff did not immediately take action to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, and LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse had occurred). Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. During the facility's investigation, LPN #1 was interviewed and stated she wanted Resident #1 to stay at the nurses' station to be monitored for the resident's behavior. Facility staff interviewed other residents on the unit and one other resident reported he/she had overheard the LPN say negative things about another resident. The investigation further stated based on the investigation abuse could not be substantiated. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. Administrator #1 acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson and he was aware an alert and oriented resident had reported witnessing LPN #1 be inappropriate and rude to another resident previously. However, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185337	A. BUILDING ______ B. WING _____	**04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490	(continued... from page 42)

determine if LPN #1 had abused Resident #1. Therefore, the allegation of abuse was unsubstantiated, and no further disciplinary action was taken against the LPN concerning the alleged abuse to Resident #1. However, review of the facility's policy revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. Further interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility's policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, the policy stated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 2. A review of the facility's first AOC, alleging removal of jeopardy on 03/06/13, revealed all staff, including the Administrator, the DON, Social Worker/Abuse Coordinator were re-educated beginning 03/04/13, on the revisions of the abuse policy. The AOC further stated that the Chief Nurse Executive reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's Social Worker/Abuse Coordinator approximately two to three months prior when the incident occurred. Resident #29 alleged that a male staff member touched her breast inappropriately and the resident was afraid of the staff person. An interview with the Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM revealed the allegation was not reported to the appropriate State Agencies and the alleged perpetrator continued to provide direct care because the facility felt it was not abuse, even though a complete investigation had not been conducted. There was no evidence the facility identified as part of their review of past investigations as stated in the AOC that this investigation was not thorough, the abuse allegation was not reported, and the resident was not protected. Administrator #1, who was the Administrator on record during this time, was no longer employed as Administrator of the facility and was not available for interview. Interview on 04/05/13 at 6:05 PM, with the Vice President of Operations who was also acting as the facility's Administrator, revealed he was not aware of the incident involving Resident #29. However, further interview on 04/05/13 at 7:30 PM, revealed he did recall Administrator #1 telling him about the incident; however, he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. Interview and review of the facility's investigation dated 04/01/13 revealed on 03/27/13 the Administrator was notified of an allegation of abuse involving RN #8 and Resident #4 that occurred on 03/24/13. A review of a facility's investigation dated 04/01/13, revealed on 03/24/13, Resident #4 alleged RN #8 was mean to the resident and the resident did not want RN #8 to provide further care for the resident and did not want RN #8 to come back to Resident #4's room. The facility interviewed Resident #4, the RN, and all residents with a Brief Interview for Mental Status (BIMS) score of 8 or higher. Based on this information, the facility unsubstantiated that abuse occurred based on Resident #4's moderately impaired cognitive ability. Interview with the DON on 04/02/13 at 8:45 PM revealed she became aware of the allegation on 03/24/13; however, did not notify the Administrator, or initiate an investigation until 03/27/13, three days later, when the Corporate Nurse Consultant questioned her regarding the incident. Interview with Administrator #2 on 03/28/13 at 2:00 PM, 6:40 PM, and on 03/29/13 at 10:25 AM, and 4:11 PM revealed he became aware of the incident on 03/27/13 around 5:40 PM. Administrator #2 stated the DON informed him she had forgotten to start an investigation related to the incident and forgot to inform him of the allegation of abuse. Further interview revealed Administrator #2 did not think it was reportable. He stated, In my heart of hearts I have gotten to know the little girl while I've been here. I just didn't feel it was true and reportable, even before the investigation had been complete. 4. A review of the facility's second AOC, dated 04/05/13, alleging removal of jeopardy on 04/05/13, revealed facility staff, including the facility Administrator, DON, and Social Worker/Abuse Coordinator, had been retrained on abuse protocols that included investigation, reporting, and protection of residents. In addition, according to the AOC, an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, interview with the facility's Social Worker/Abuse Coordinator on 04/09/13 revealed four other allegations of resident abuse involving Residents #19, #29, #30, and #31 had been reported to facility staff and there was no evidence the abuse allegations had been reported to the appropriate State Agencies, had been thoroughly investigated, or that facility residents had been protected from further potential abuse. In addition, review of the facility's abuse log revealed no entry for the abuse allegations involving Residents #19, #29, #30, and #31. An interview with Administrator #2 on 04/09/13 at 5:45 PM, revealed the abuse log was not effective to identify facility failures to investigate, report, and protect Residents #19, #29, #30, and #31 when an allegation was reported. Administrator #2 stated he was not aware of these allegations of abuse. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. The Administrator of record during the time of the alleged abuse allegations, Administrator #1, has been suspended by the Chief Operating Officer on 04/05/13. An investigation has been initiated. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a post-test. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ---Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, and a review of a statement written by the Chief Operating Officer dated 04/22/13 revealed he suspended the Administrator of record on 04/05/13, Administrator #1. Interview with on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 1:46 PM with the Clinical Regional Nurse Consultant; at 2:12 PM with the Chief Operating Officer; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 12:57 PM with the Central Supply and Staffing Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; at 1:23 PM with the Staff Development Coordinator; and at 1:40 PM with the Director of Maintenance confirmed they had received training on abuse by the Independent Contractor on 04/06/13 and had completed a post test. The above Regional Staff and Department Directors verified they had also assisted with education of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**
NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET** **BEATTYVILLE, KY 41311**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0490	(continued... from page 43) the remaining staff on 04/12/13. Review of post-test and interviews on 04/23/13 at 10:35 AM with State Registered Nurse Aide (SRNA) #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:05 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #9; at 12:38 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 confirmed they were re-educated by Department Directors and/or Regional Staff. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the DON; and at 12:38 PM with the Interim Social Services Director revealed the Independent Contractor did provide them with one on one education related to protection, reporting, and investigation of allegations of abuse prior to 04/12/13. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis. ---During a complaint investigation (KY) conducted in conjunction with the revisit, an additional example of noncompliance was identified. Interview, review of the facility investigation and review of the facility's Abuse, Neglect and Misappropriation Policy, revealed the facility failed to be administered in a manner that maintained the highest physical well-being for Resident #32. The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure allegations of abuse were reported to the State Survey Agency in a timely manner. (Refer to F225 and F226.) A review of the facility's Abuse, Neglect and Misappropriation policy, revised March 2013 and effective April 2013, revealed, all allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with officials in accordance with State law through established guidelines. A review of the facility's investigation report revealed on 04/17/13, at approximately 10:50 AM, Licensed Practical Nurse (LPN) #5 reported to the facility's Administration that Kentucky Medication Aide (KMA) #6 reported an allegation that had been made against her (KMA #6). According to the facility's investigation, while KMA #6 was providing care to Resident #32 that morning (04/17/13), the resident told KMA #6 that she was pulling the resident's hair and trying to kill the resident. According to documentation on the report, the alleged perpetrator (KMA #6) was immediately suspended and an investigation was initiated. The report further revealed the allegation was reported to the State Survey Agency on 04/18/13 at 5:52 PM (a timeframe of 31 hours after the allegation had been reported to the administration of the facility). Interview on 04/22/13 at 2:15 PM with the Chief Nurse Executive (CNE) revealed the regulatory guidelines indicated reporting of an allegation of abuse ought not to exceed 24 hours, and had interpreted the statement to mean the facility could have more time to report if necessary. The interview further revealed the CNE thought the time frame was in business hours and the facility was a 24-hour business. Administrator #2 acknowledged in interview on 04/22/13 at 1:58 PM that the facility had not reported the incident until 04/18/13 at 5:52 PM even though the facility staff had reported the incident to Administration at approximately 10:50 AM on 04/17/13. According to the Administrator, he thought the facility had until midnight the day after an incident had been reported to make the report and stated he thought the 24-hour timeframe was from midnight on the day the incident occurred to midnight the day after the incident occurred.
F 0490	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to be administered in a manner that maintained the highest physical well-being for six of twenty-nine sampled residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure staff immediately reported allegations of abuse to Administration and to the appropriate State Agencies; failed to ensure all residents were protected from abuse during facility investigations; and failed to ensure thorough investigations had been conducted related to abuse allegations. (Refer to F223, F225, F226, and F520.) The Administration's failure to ensure facility policies/procedures related to abuse prevention were developed and implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated, Any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, Any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 1. Interview and review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying, wanting to go to bed. Staff reported LPN #1, the Charge Nurse, would not allow staff to assist the resident to bed due to the resident yelling, whining, and crying. One staff member reported LPN #1 made the comment that she was going to teach the resident a lesson. Interviews revealed staff did not immediately take action to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, and LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse had occurred). Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. During the facility's investigation, LPN #1 was interviewed and stated she wanted Resident #1 to stay at the nurses' station to be monitored for the resident's behavior. Facility staff interviewed other residents on the unit and one other resident reported he/she had overheard the LPN say negative things about another resident. The investigation further stated based on the investigation abuse could not be substantiated. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed his investigation of the alleged abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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F 0490

(continued... from page 44)
consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. Administrator #1 acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson and he was aware an alert and oriented resident had reported witnessing LPN #1 be inappropriate and rude to another resident previously. However, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1. Therefore, the allegation of abuse was unsubstantiated, and no further disciplinary action was taken against the LPN concerning the alleged abuse to Resident #1. However, review of the facility's policy revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. Further interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility's policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, the policy stated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 2. A review of the facility's first AOC, alleging removal of jeopardy on 03/06/13, revealed all staff, including the Administrator, the DON, Social Worker/Abuse Coordinator were re-educated beginning 03/04/13, on the revisions of the abuse policy. The AOC further stated that the Chief Nurse Executive reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's Social Worker/Abuse Coordinator approximately two to three months prior when the incident occurred. Resident #29 alleged that a male staff member touched her breast inappropriately and the resident was afraid of the staff person. An interview with the Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM revealed the allegation was not reported to the appropriate State Agencies and the alleged perpetrator continued to provide direct care because the facility felt it was not abuse, even though a complete investigation had not been conducted. There was no evidence the facility identified as part of their review of past investigations as stated in the AOC that this investigation was not thorough, the abuse allegation was not reported, and the resident was not protected. Administrator #1, who was the Administrator on record during this time, was no longer employed as Administrator of the facility and was not available for interview. Interview on 04/05/13 at 6:05 PM, with the Vice President of Operations who was also acting as the facility's Administrator, revealed he was not aware of the incident involving Resident #29. However, further interview on 04/05/13 at 7:30 PM, revealed he did recall Administrator #1 telling him about the incident; however, he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. Interview and review of the facility's investigation dated 04/01/13 revealed on 03/27/13 the Administrator was notified of an allegation of abuse involving RN #8 and Resident #4 that occurred on 03/24/13. A review of a facility's investigation dated 04/01/13, revealed on 03/24/13, Resident #4 alleged RN #8 was mean to the resident and the resident did not want RN #8 to provide further care for the resident and did not want RN #8 to come back to Resident #4's room. The facility interviewed Resident #4, the RN, and all residents with a Brief Interview for Mental Status (BIMS) score of 8 or higher. Based on this information, the facility unsubstantiated that abuse occurred based on Resident #4's moderately impaired cognitive ability. Interview with the DON on 04/02/13 at 8:45 PM revealed she became aware of the allegation on 03/24/13; however, did not notify the Administrator, or initiate an investigation until 03/27/13, three days later, when the Corporate Nurse Consultant questioned her regarding the incident. Interview with Administrator #2 on 03/28/13 at 2:00 PM, 6:40 PM, and on 03/29/13 at 10:25 AM, and 4:11 PM revealed he became aware of the incident on 03/27/13 around 5:40 PM. Administrator #2 stated the DON informed him she had forgotten to start an investigation related to the incident and forgot to inform him of the allegation of abuse. Further interview revealed Administrator #2 did not think it was reportable. He stated, In my heart of hearts I have gotten to know the little girl while I've been here. I just didn't feel it was true and reportable, even before the investigation had been complete. 4. A review of the facility's second AOC, dated 04/05/13, alleging removal of jeopardy on 04/05/13, revealed facility staff, including the facility Administrator, DON, and Social Worker/Abuse Coordinator, had been retrained on abuse protocols that included investigation, reporting, and protection of residents. In addition, according to the AOC, an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, interview with the facility's Social Worker/Abuse Coordinator on 04/09/13 revealed four other allegations of resident abuse involving Residents #19, #29, #30, and #31 had been reported to facility staff and there was no evidence the abuse allegations had been reported to the appropriate State Agencies, had been thoroughly investigated, or that facility residents had been protected from further potential abuse. In addition, review of the facility's abuse log revealed no entry for the abuse allegations involving Residents #19, #29, #30, and #31. An interview with Administrator #2 on 04/09/13 at 5:45 PM, revealed the abuse log was not effective to identify facility failures to investigate, report, and protect Residents #19, #29, #30, and #31 when an allegation was reported. Administrator #2 stated he was not aware of these allegations of abuse. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. The Administrator of record during the time of the alleged abuse allegations, Administrator #1, has been suspended by the Chief Operating Officer on 04/05/13. An investigation has been initiated. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a post-test. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ---Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, and a review of a statement written by the Chief Operating Officer dated 04/22/13 revealed he suspended the Administrator of record on 04/05/13, Administrator #1. Interview with on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 1:46 PM with the Clinical Regional Nurse Consultant; at 2:12 PM with the Chief Operating Officer; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0490	(continued... from page 45) at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 12:57 PM with the Central Supply and Staffing Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; at 1:23 PM with the Staff Development Coordinator; and at 1:40 PM with the Director of Maintenance confirmed they had received training on abuse by the Independent Contractor on 04/06/13 and had completed a post test. The above Regional Staff and Department Directors verified they had also assisted with education of the remaining staff on 04/12/13. Review of post-test and interviews on 04/23/13 at 10:35 AM with State Registered Nurse Aide (SRNA) #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:05 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #9; at 12:38 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 confirmed they were re-educated by Department Directors and/or Regional Staff. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the DON; and at 12:38 PM with the Interim Social Services Director revealed the Independent Contractor did provide them with one on one education related to protection, reporting, and investigation of allegations of abuse prior to 04/12/13. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis. ---During a complaint investigation (KY) conducted in conjunction with the revisit, an additional example of noncompliance was identified. Interview, review of the facility investigation and review of the facility's Abuse, Neglect and Misappropriation Policy, revealed the facility failed to be administered in a manner that maintained the highest physical well-being for Resident #32. The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure allegations of abuse were reported to the State Survey Agency in a timely manner. (Refer to F225 and F226.) A review of the facility's Abuse, Neglect and Misappropriation policy, revised March 2013 and effective April 2013, revealed, all allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with officials in accordance with State law through established guidelines. A review of the facility's investigation report revealed on 04/17/13, at approximately 10:50 AM, Licensed Practical Nurse (LPN) #5 reported to the facility's Administration that Kentucky Medication Aide (KMA) #6 reported an allegation that had been made against her (KMA #6). According to the facility's investigation, while KMA #6 was providing care to Resident #32 that morning (04/17/13), the resident told KMA #6 that she was pulling the resident's hair and trying to kill the resident. According to documentation on the report, the alleged perpetrator (KMA #6) was immediately suspended and an investigation was initiated. The report further revealed the allegation was reported to the State Survey Agency on 04/18/13 at 5:52 PM (a timeframe of 31 hours after the allegation had been reported to the administration of the facility). Interview on 04/22/13 at 2:15 PM with the Chief Nurse Executive (CNE) revealed the regulatory guidelines indicated reporting of an allegation of abuse ought not to exceed 24 hours, and had interpreted the statement to mean the facility could have more time to report if necessary. The interview further revealed the CNE thought the time frame was in business hours and the facility was a 24-hour business. Administrator #2 acknowledged in interview on 04/22/13 at 1:58 PM that the facility had not reported the incident until 04/18/13 at 5:52 PM even though the facility staff had reported the incident to Administration at approximately 10:50 AM on 04/17/13. According to the Administrator, he thought the facility had until midnight the day after an incident had been reported to make the report and stated he thought the 24-hour timeframe was from midnight on the day the incident occurred to midnight the day after the incident occurred.
F 0490	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on interview, record review, and review of the facility's investigation and policy and procedures it was determined the facility failed to be administered in a manner that maintained the highest physical well-being for six of twenty-nine sampled residents (Residents #1, #4, #19, #29, #30, and #31). The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure staff immediately reported allegations of abuse to Administration and to the appropriate State Agencies; failed to ensure all residents were protected from abuse during facility investigations; and failed to ensure thorough investigations had been conducted related to abuse allegations. (Refer to F223, F225, F226, and F520.) The Administration's failure to ensure facility policies/procedures related to abuse prevention were developed and implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13 and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's abuse policy, dated 01/2012, revealed it was the intent of the facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or reasonable suspicion of criminal act or intent. The policy stated, Any report or suspicion of an incident was to be reported immediately to the charge nurse, and the Administrator, Director of Nursing and Abuse Coordinator, as appropriate, were to be notified immediately by the charge nurse who receives the report. Further review revealed, Any report or suspicion of an incident of abuse was to be immediately reported to the charge nurse and/or Abuse Coordinator, as appropriate. The policy also revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them; and that the resident was to receive measures to ensure his or her immediate safety and wellbeing following the incident and during the investigation process. The policy further stated the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 1. Interview and review of the facility's investigation, dated 02/22/13, revealed on the morning of 02/17/13, after the morning meal, staff observed Resident #1 at the nurses' station crying, wanting to go to bed. Staff reported LPN #1, the Charge Nurse, would not allow staff to assist the resident to bed due to the resident yelling, whining, and crying. One staff member reported LPN #1 made the comment that she was going to teach the resident a lesson. Interviews revealed staff did not immediately take action to protect residents in the facility or notify appropriate facility personnel until approximately 11:30 AM, and LPN #1 continued to be in charge of resident care and remained on the floor with residents until 12:30 PM (five hours after the abuse had occurred). Further review revealed LPN #1 was immediately suspended pending the outcome of the investigation. During the facility's investigation, LPN #1 was interviewed and stated she wanted Resident #1 to stay at the nurses' station to be monitored for the resident's

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0490	(continued... from page 46) behavior. Facility staff interviewed other residents on the unit and one other resident reported he/she had overheard the LPN say negative things about another resident. The investigation further stated based on the investigation abuse could not be substantiated. Interview with Administrator #1 on 02/28/13 at 5:20 PM revealed his investigation of the alleged abuse consisted of reviewing witness statements, information that had been obtained, consulting with his regional staff, and interviewing LPN #1, the Charge Nurse. Administrator #1 acknowledged he had been aware of the staff interviews and witness statements describing the LPN's (Charge Nurse) intentions to teach (Resident #1) a lesson and he was aware an alert and oriented resident had reported witnessing LPN #1 be inappropriate and rude to another resident previously. However, he had concluded that staff might have misinterpreted the LPN's actions, and stated he was unable to come to a firm conclusion or determine if LPN #1 had abused Resident #1. Therefore, the allegation of abuse was unsubstantiated, and no further disciplinary action was taken against the LPN concerning the alleged abuse to Resident #1. However, review of the facility's policy revealed a thorough investigation was to be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who had potential knowledge of the incident; the Administrator/designee would make all reasonable efforts to investigate and address alleged reports, concerns, and grievances presented to them. Further interview with Administrator #1 on 03/05/13 at 4:25 PM revealed he was not aware the facility's policy did not instruct staff to immediately remove the alleged perpetrator from direct resident care. However, the policy stated only the Administrator and/or DON and/or Social Worker would make any immediate decisions related to the removal of individuals from direct care giving or direct contact related to the alleged or suspected abuse. 2. A review of the facility's first AOC, alleging removal of jeopardy on 03/06/13, revealed all staff, including the Administrator, the DON, Social Worker/Abuse Coordinator were re-educated beginning 03/04/13, on the revisions of the abuse policy. The AOC further stated that the Chief Nurse Executive reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's Social Worker/Abuse Coordinator approximately two to three months prior when the incident occurred. Resident #29 alleged that a male staff member touched her breast inappropriately and the resident was afraid of the staff person. An interview with the Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM revealed the allegation was not reported to the appropriate State Agencies and the alleged perpetrator continued to provide direct care because the facility felt it was not abuse, even though a complete investigation had not been conducted. There was no evidence the facility identified as part of their review of past investigations as stated in the AOC that this investigation was not thorough, the abuse allegation was not reported, and the resident was not protected. Administrator #1, who was the Administrator on record during this time, was no longer employed as Administrator of the facility and was not available for interview. Interview on 04/05/13 at 6:05 PM, with the Vice President of Operations who was also acting as the facility's Administrator, revealed he was not aware of the incident involving Resident #29. However, further interview on 04/05/13 at 7:30 PM, revealed he did recall Administrator #1 telling him about the incident; however, he could not recall the resident's name and did not ask additional questions related to that resident's concern. 3. Interview and review of the facility's investigation dated 04/01/13 revealed on 03/27/13 the Administrator was notified of an allegation of abuse involving RN #8 and Resident #4 that occurred on 03/24/13. A review of a facility's investigation dated 04/01/13, revealed on 03/24/13, Resident #4 alleged RN #8 was mean to the resident and the resident did not want RN #8 to provide further care for the resident and did not want RN #8 to come back to Resident #4's room. The facility interviewed Resident #4, the RN, and all residents with a Brief Interview for Mental Status (BIMS) score of 8 or higher. Based on this information, the facility unsubstantiated that abuse occurred based on Resident #4's moderately impaired cognitive ability. Interview with the DON on 04/02/13 at 8:45 PM revealed she became aware of the allegation on 03/24/13; however, did not notify the Administrator, or initiate an investigation until 03/27/13, three days later, when the Corporate Nurse Consultant questioned her regarding the incident. Interview with Administrator #2 on 03/28/13 at 2:00 PM, 6:40 PM, and on 03/29/13 at 10:25 AM, and 4:11 PM revealed he became aware of the incident on 03/27/13 around 5:40 PM. Administrator #2 stated the DON informed him she had forgotten to start an investigation related to the incident and forgot to inform him of the allegation of abuse. Further interview revealed Administrator #2 did not think it was reportable. He stated, In my heart of hearts I have gotten to know the little girl while I've been here. I just didn't feel it was true and reportable, even before the investigation had been complete. 4. A review of the facility's second AOC, dated 04/05/13, alleging removal of jeopardy on 04/05/13, revealed facility staff, including the facility Administrator, DON, and Social Worker/Abuse Coordinator, had been retrained on abuse protocols that included investigation, reporting, and protection of residents. In addition, according to the AOC, an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, interview with the facility's Social Worker/Abuse Coordinator on 04/09/13 revealed four other allegations of resident abuse involving Residents #19, #29, #30, and #31 had been reported to facility staff and there was no evidence the abuse allegations had been reported to the appropriate State Agencies, had been thoroughly investigated, or that facility residents had been protected from further potential abuse. In addition, review of the facility's abuse log revealed no entry for the abuse allegations involving Residents #19, #29, #30, and #31. An interview with Administrator #2 on 04/09/13 at 5:45 PM, revealed the abuse log was not effective to identify facility failures to investigate, report, and protect Residents #19, #29, #30, and #31 when an allegation was reported. Administrator #2 stated he was not aware of these allegations of abuse. ---The facility provided an acceptable (AOC) on 04/17/13, which alleged the removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. The Administrator of record during the time of the alleged abuse allegations, Administrator #1, has been suspended by the Chief Operating Officer on 04/05/13. An investigation has been initiated. All staff including Department Directors and Regional Staff received education regarding abuse, completed by an Independent Contractor by 04/06/13, with completion of a post-test. All staff were re-educated by the Department Directors and Regional Team on 04/12/13. Staff not scheduled, on leave or who work as needed will be re-educated upon returning to work. The Independent Contractor was secured on 04/07/13 to remain onsite at the facility daily until 04/13/13 to provide continued oversight and education related to abuse, to include investigation, reporting, and protection. The Independent Contractor will provide one on one education with Administrator #2, Director of Nursing, and the Interim Social Services Director regarding protection, reporting, and investigation of allegations of abuse by 04/12/13. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ---Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, and a review of a statement written by the Chief Operating Officer dated 04/22/13 revealed he suspended the Administrator of record on 04/05/13,

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F 0490	(continued... from page 47) Administrator #1. Interview with on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 1:46 PM with the Clinical Regional Nurse Consultant; at 2:12 PM with the Chief Operating Officer; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 12:57 PM with the Central Supply and Staffing Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; at 1:23 PM with the Staff Development Coordinator; and at 1:40 PM with the Director of Maintenance confirmed they had received training on abuse by the Independent Contractor on 04/06/13 and had completed a post test. The above Regional Staff and Department Directors verified they had also assisted with education of the remaining staff on 04/12/13. Review of post-test and interviews on 04/23/13 at 10:35 AM with State Registered Nurse Aide (SRNA) #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:05 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #9; at 12:38 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 confirmed they were re-educated by Department Directors and/or Regional Staff. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the DON; and at 12:38 PM with the Interim Social Services Director revealed the Independent Contractor did provide them with one on one education related to protection, reporting, and investigation of allegations of abuse prior to 04/12/13. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis. ---During a complaint investigation (KY) conducted in conjunction with the revisit, an additional example of noncompliance was identified. Interview, review of the facility investigation and review of the facility's Abuse, Neglect and Misappropriation Policy, revealed the facility failed to be administered in a manner that maintained the highest physical well-being for Resident #32. The facility failed to have an effective system in place to ensure policies and procedures were developed/implemented to ensure allegations of abuse were reported to the State Survey Agency in a timely manner. (Refer to F225 and F226.) A review of the facility's Abuse, Neglect and Misappropriation policy, revised March 2013 and effective April 2013, revealed, all allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with officials in accordance with State law through established guidelines. A review of the facility's investigation report revealed on 04/17/13, at approximately 10:50 AM, Licensed Practical Nurse (LPN) #5 reported to the facility's Administration that Kentucky Medication Aide (KMA) #6 reported an allegation that had been made against her (KMA #6). According to the facility's investigation, while KMA #6 was providing care to Resident #32 that morning (04/17/13), the resident told KMA #6 that she was pulling the resident's hair and trying to kill the resident. According to documentation on the report, the alleged perpetrator (KMA #6) was immediately suspended and an investigation was initiated. The report further revealed the allegation was reported to the State Survey Agency on 04/18/13 at 5:52 PM (a timeframe of 31 hours after the allegation had been reported to the administration of the facility). Interview on 04/22/13 at 2:15 PM with the Chief Nurse Executive (CNE) revealed the regulatory guidelines indicated reporting of an allegation of abuse ought not to exceed 24 hours, and had interpreted the statement to mean the facility could have more time to report if necessary. The interview further revealed the CNE thought the time frame was in business hours and the facility was a 24-hour business. Administrator #2 acknowledged in interview on 04/22/13 at 1:58 PM that the facility had not reported the incident until 04/18/13 at 5:52 PM even though the facility staff had reported the incident to Administration at approximately 10:50 AM on 04/17/13. According to the Administrator, he thought the facility had until midnight the day after an incident had been reported to make the report and stated he thought the 24-hour timeframe was from midnight on the day the incident occurred to midnight the day after the incident occurred.
F 0514	**Keep accurate, complete and organized clinical records on each resident that meet professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure clinical records were maintained in accordance with accepted professional standards and practices and contained accurate documentation for four of twenty-nine sampled residents (Residents #4, #29, #30, and #31). Interviews revealed Residents #4, #29, #30, and #31 reported allegations of abuse to the facility; however, there was no evidence the facility had documented any of the allegations/reports in the resident's medical record. The findings include: 1. A review of the facility policy, False Claims Act, dated 01/01/08, revealed it was the policy of the company to be committed to its role in preventing health care fraud and abuse. An example of a false claim was to falsify information in the medical record. A review of an initial investigation of an abuse allegation dated 03/27/13, signed by Administrator #2 revealed during the investigation it appears the Director of Nursing (DON) encouraged the Registered Nurse (RN) to rewrite a note and replace the original note in the resident's medical record. A review of Resident #4's medical record on 03/28/13 revealed nurse's notes dated 03/23/13. A nurse's note written on 03/23/13 at 12:30 AM revealed, Answering Res alarm sounding in room, Res noted on toilet in bathroom at this time. Stating to Res to use call light at beside to ring for staff assistance with ambulation to bathroom. Res states 'you shut your mouth. You don't have any right to quarrel at me. Your mouth is going just like a duck's mouth. Now you just shut up and leave me alone.' This nurse stating to Res will remain in room and assist to ambulate back to bed when finished to prevent falling, will continue to mx Res, and was signed by Registered Nurse (RN) #8. A second note at 3:30 AM revealed, Answering Res call light at this time. Res states she needs to urinate at this time. Res assisted to sit up in bed. Res assisted to bathroom. Res appears agitated, continues to get up without assistance, refuses to use call light. Will continue to mx, and was also signed by RN #8. Interview with Administrator #2 on 03/28/13 at 6:40 PM revealed on 03/27/13, the DON was interviewing RN #8 related to the abuse allegation. Administrator #2 stated he was half paying attention when he heard a comment about doing late notes. Administrator #2 stated he then came to the conclusion the DON was going to have RN #8 take the nurse's notes out of Resident #4's medical record regarding the alleged abuse on 03/24/13 and rewrite the nurse's note. Administrator #2 stated he asked the DON, Is that not part of the record? Further interview revealed the DON stated to the Administrator that since that was the only note on the page the nurse could write a clarification note. Administrator #2 stated the DON said the nurse's note was not part of the medical record, and then removed the note from the record, and RN #8 rewrote the nurse's note for 03/24/13. Further interview revealed Administrator #2 did not agree with the rewriting of the nurse's note; however, he stated the DON has been a nurse for 18 to [AGE] years so he assumed she knew what she was doing. Interview with the DON on 04/02/13 at 8:45 PM revealed during an interview with RN #8 on 03/27/13 that she explained to the RN she needed to document Resident #4's noncompliance, and told her what to document. The DON stated she had RN #8 to write it down on a new nurse's note since the original note only had one entry written on it. The DON stated she pulled the original nurse's note out of the chart and asked Administrator #2 what to do with the original note. Administrator #2 stated to the DON that he would shred it, so the DON stated she tore it up. The DON further stated she knew it was wrong to tear up the original nurse's notes, it made me sick to my stomach. Interview with RN #8 on 03/28/13 at 8:07 PM revealed when she was interviewed on 03/27/13 by the DON regarding the abuse allegation, the DON informed her she

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F 0514	(continued... from page 48) didn't have to put everything that transpired in the nurse's notes. According to RN #8, the DON had her to rewrite the nurse's note dated 03/24/13 in Resident #4's medical record to indicate the resident was well through the shift with no further behaviors. RN #8 stated she completed the documentation but was not aware the original nurse's note was going to be removed from Resident #4's medical record. On 03/29/13, Administrator #2 provided the nurse's note that had been removed from Resident #4's medical record, which according to the DON had been torn up. Review of the nurse's notes at 3:30 AM revealed, Answering Res call light at this time. Resident states she needs to urinate at this time. Res assisted to sit up in bed. Res stating 'Honey, what's your name?' This nurse stating name. Res stating 'I think I've seen you before. Do I know you?' This nurse stating yes, Res states 'Honey, I hate to say this, but you were mean to me last night.' Res continuing to state 'I have to pee,' assisted to bathroom and assisted to ambulate back to bed. Res stating 'Honey, I don't want you to come in my room anymore. We just can't get along. I'm going to pee without anybody!' Res encouraged to use call light for assistance with ambulation to bathroom, assured CNA would assist with ambulation if Res no longer wished for this nurse to do so. Will continue to mx. The note was signed by RN #8. 2. Interview conducted with Administrator #2 on 04/09/13 at 6:15 PM, revealed the facility did not have a policy that addressed what was required to be documented in the medical record. In an interview conducted with Resident #29 on 04/05/13, at 5:50 PM, the resident stated he/she was afraid of State Registered Nurse Aide (SRNA) #14. The resident further reported SRNA #14 touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated he/she reported this incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported to her that SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she was not sure if allegations of abuse should be documented in the resident's medical record, but believed any resident concern should be documented in the record. The Social Worker/Abuse Coordinator stated she had not documented the allegation in the medical record for Resident #29. Review of the Social Worker/Abuse Coordinator progress notes confirmed the Social Worker/Abuse Coordinator had failed to document the alleged incident that had been reported to the Social Worker/Abuse Coordinator on 03/01/13 in Resident #29's medical record. 3. A review of a facility's investigation revealed on 03/24/13 Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. However, a review of the medical record, including nurse's notes and Social Services Notes for Resident #30, revealed no evidence of documentation of the allegation made by Resident #30 to facility staff on 03/22/13, the day the incident occurred, and did not contain any documentation related to the incident after the facility became aware of the allegation on 04/08/13. 4. Interview with Administrator #2 at 5:00 PM revealed Administrator #2 had talked with staff on 04/09/13 about an allegation reported on 04/08/13 by the Social Worker/Abuse Coordinator that Resident #31 may have been set down in a chair too hard by facility staff. The incident reportedly occurred during the timeframe of 03/17-19/13. A review of the medical record for Resident #31, including nurse's notes and Social Services Progress Notes for the period of 03/01/13 to 04/09/13, revealed facility staff failed to document detailed information related to the allegation of abuse that occurred during the timeframe noted. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had not documented any information regarding allegations of abuse in the Social Services Progress notes regarding Resident #31. Interview conducted with Administrator #2 on 04/09/13 at 5:45 PM revealed he was not familiar with the facility's documentation policies. Administrator #2 stated he would think the Social Worker/Abuse Coordinator should have documented the alleged incidents in the Social Services Progress Notes in the medical record.
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F 0514

(continued... from page 50)
allegation made by Resident #30 to facility staff on 03/22/13, the day the incident occurred, and did not contain any documentation related to the incident after the facility became aware of the allegation on 04/08/13. 4. Interview with Administrator #2 at 5:00 PM revealed Administrator #2 had talked with staff on 04/09/13 about an allegation reported on 04/08/13 by the Social Worker/Abuse Coordinator that Resident #31 may have been set down in a chair too hard by facility staff. The incident reportedly occurred during the timeframe of 03/17-19/13. A review of the medical record for Resident #31, including nurse's notes and Social Services Progress Notes for the period of 03/01/13 to 04/09/13, revealed facility staff failed to document detailed information related to the allegation of abuse that occurred during the timeframe noted. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had not documented any information regarding allegations of abuse in the Social Services Progress notes regarding Resident #31. Interview conducted with Administrator #2 on 04/09/13 at 5:45 PM revealed he was not familiar with the facility's documentation policies. Administrator #2 stated he would think the Social Worker/Abuse Coordinator should have documented the alleged incidents in the Social Services Progress Notes in the medical record.

F 0514

Keep accurate, complete and organized clinical records on each resident that meet professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility failed to ensure clinical records were maintained in accordance with accepted professional standards and practices and contained accurate documentation for four of twenty-nine sampled residents (Residents #4, #29, #30, and #31). Interviews revealed Residents #4, #29, #30, and #31 reported allegations of abuse to the facility; however, there was no evidence the facility had documented any of the allegations/reports in the resident's medical record. The findings include: 1. A review of the facility policy, False Claims Act, dated 01/01/08, revealed it was the policy of the company to be committed to its role in preventing health care fraud and abuse. An example of a false claim was to falsify information in the medical record. A review of an initial investigation of an abuse allegation dated 03/27/13, signed by Administrator #2 revealed during the investigation it appears the Director of Nursing (DON) encouraged the Registered Nurse (RN) to rewrite a note and replace the original note in the resident's medical record. A review of Resident #4's medical record on 03/28/13 revealed nurse's notes dated 03/23/13. A nurse's note written on 03/23/13 at 12:30 AM revealed, Answering Res alarm sounding in room, Res noted on toilet in bathroom at this time. Stating to Res to use call light at beside to ring for staff assistance with ambulation to bathroom. Res states 'you shut your mouth. You don't have any right to quarrel at me. Your mouth is going just like a duck's mouth. Now you just shut up and leave me alone.' This nurse stating to Res will remain in room and assist to ambulate back to bed when finished to prevent falling, will continue to mx Res, and was signed by Registered Nurse (RN) #8. A second note at 3:30 AM revealed, Answering Res call light at this time. Res states she needs to urinate at this time. Res assisted to sit up in bed. Res assisted to bathroom. Res appears agitated, continues to get up without assistance, refuses to use call light. Will continue to mx, and was also signed by RN #8. Interview with Administrator #2 on 03/28/13 at 6:40 PM revealed on 03/27/13, the DON was interviewing RN #8 related to the abuse allegation. Administrator #2 stated he was half paying attention when he heard a comment about doing late notes. Administrator #2 stated he then came to the conclusion the DON was going to have RN #8 take the nurse's notes out of Resident #4's medical record regarding the alleged abuse on 03/24/13 and rewrite the nurse's note. Administrator #2 stated he asked the DON, Is that not part of the record? Further interview revealed the DON stated to the Administrator that since that was the only note on the page the nurse could write a clarification note. Administrator #2 stated the DON said the nurse's note was not part of the medical record, and then removed the note from the record, and RN #8 rewrote the nurse's note for 03/24/13. Further interview revealed Administrator #2 did not agree with the rewriting of the nurse's note; however, he stated the DON has been a nurse for 18 to [AGE] years so he assumed she knew what she was doing. Interview with the DON on 04/02/13 at 8:45 PM revealed during an interview with RN #8 on 03/27/13 that she explained to the RN she needed to document Resident #4's noncompliance, and told her what to document. The DON stated she had RN #8 to write it down on a new nurse's note since the original note only had one entry written on it. The DON stated she pulled the original nurse's note out of the chart and asked Administrator #2 what to do with the original note. Administrator #2 stated to the DON that he would shred it, so the DON stated she tore it up. The DON further stated she knew it was wrong to tear up the original nurse's notes, it made me sick to my stomach. Interview with RN #8 on 03/28/13 at 8:07 PM revealed when she was interviewed on 03/27/13 by the DON regarding the abuse allegation, the DON informed her she didn't have to put everything that transpired in the nurse's notes. According to RN #8, the DON had her to rewrite the nurse's note dated 03/24/13 in Resident #4's medical record to indicate the resident was well through the shift with no further behaviors. RN #8 stated she completed the documentation but was not aware the original nurse's note was going to be removed from Resident #4's medical record. On 03/29/13, Administrator #2 provided the nurse's note that had been removed from Resident #4's medical record, which according to the DON had been torn up. Review of the nurse's notes at 3:30 AM revealed, Answering Res call light at this time. Resident states she needs to urinate at this time. Res assisted to sit up in bed. Res stating 'Honey, what's your name?' This nurse stating name. Res stating 'I think I've seen you before. Do I know you?' This nurse stating yes, Res states 'Honey, I hate to say this, but you were mean to me last night.' Res continuing to state 'I have to pee,' assisted to bathroom and assisted to ambulate back to bed. Res stating 'Honey, I don't want you to come in my room anymore. We just can't get along. I'm going to pee without anybody!' Res encouraged to use call light for assistance with ambulation to bathroom, assured CNA would assist with ambulation if Res no longer wished for this nurse to do so. Will continue to mx. The note was signed by RN #8. 2. Interview conducted with Administrator #2 on 04/09/13 at 6:15 PM, revealed the facility did not have a policy that addressed what was required to be documented in the medical record. In an interview conducted with Resident #29 on 04/05/13, at 5:50 PM, the resident stated he/she was afraid of State Registered Nurse Aide (SRNA) #14. The resident further reported SRNA #14 touched the resident's breast while hugging the resident two to three months ago. Resident #29 stated he/she reported this incident to the Social Worker/Abuse Coordinator. Interview conducted with the Social Worker/Abuse Coordinator on 04/05/13, at 6:50 PM confirmed Resident #29 reported to her that SRNA #14 touched the resident's breast on 03/01/13. According to the Social Worker/Abuse Coordinator, she was not sure if allegations of abuse should be documented in the resident's medical record, but believed any resident concern should be documented in the record. The Social Worker/Abuse Coordinator stated she had not documented the allegation in the medical record for Resident #29. Review of the Social Worker/Abuse Coordinator progress notes confirmed the Social Worker/Abuse Coordinator had failed to document the alleged incident that had been reported to the Social Worker/Abuse Coordinator on 03/01/13 in Resident #29's medical record. 3. A review of a facility's investigation revealed on 03/24/13 Resident #30 alleged that SRNA #13 had repeatedly sprayed cold water on the resident during a shower and had wrapped a sheet around the resident's neck too tight following the shower on 03/22/13 from 8:00 PM to 9:00 PM. However, a review of the medical record, including nurse's notes and Social Services Notes for Resident #30, revealed no evidence of documentation of the allegation made by Resident #30 to facility staff on 03/22/13, the day the incident occurred, and did not contain any documentation related to the incident after the facility became aware of the allegation on 04/08/13. 4. Interview with Administrator #2 at 5:00 PM revealed Administrator #2 had talked with staff on 04/09/13 about an allegation reported on 04/08/13 by the Social Worker/Abuse Coordinator that Resident #31 may have been set down in a chair too hard by facility staff. The incident reportedly occurred during the timeframe of 03/17-19/13. A review of the medical record for Resident #31, including nurse's notes and Social Services Progress Notes for the period of 03/01/13 to 04/09/13, revealed facility staff failed to document detailed information related to the allegation of abuse that occurred during the timeframe noted. An interview conducted with the facility Social Worker/Abuse Coordinator on 04/09/13 at 11:09 AM, revealed the Social Worker/Abuse Coordinator had not documented any information regarding allegations of abuse in the Social Services Progress notes regarding Resident #31. Interview conducted with Administrator #2 on 04/09/13 at 5:45 PM revealed he was not familiar with the facility's documentation policies. Administrator #2 stated he would think the Social Worker/Abuse Coordinator should have documented the alleged incidents in the Social Services Progress Notes in the medical record.

F 0518

Train all employees on what to do in an emergency, and carry out announced staff drills.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0518	(continued... from page 51) Based on interview and record review it was determined the facility failed to ensure emergency fire procedures were periodically reviewed with one of three existing staff members. A Laundry Aide was not knowledgeable regarding the procedures to implement in the event there was a fire in the Laundry. The findings include: A review of the facility's Fire Safety Procedure Plan, dated January 2005, revealed if a fire was discovered in the laundry area staff was to pull the nearest fire alarm and fight the fire with a portable fire extinguisher. An interview conducted on 04/03/13 at 10:15 AM, with a Laundry Aide who had been assigned to the Laundry on 04/03/13, revealed the Laundry Aide was not aware of the procedure to take in the event of a fire in the laundry area. The Laundry Aide stated that even though she had participated in a fire drill on the C Wing of the facility, she had not participated in a fire drill in the laundry area. According to the Laundry Aide, during the fire drill on the C Wing, another housekeeping staff person instructed her on what to do during the fire drill because the facility had not trained her on the procedures to take in the event of a fire at the facility. A review of the facility's employee training for fire safety revealed a post test had been completed by the Laundry Aide on 06/26/12 that revealed the Laundry Aide had been trained regarding the facility's general fire procedures; however, it could not be determined that the training included the laundry area. An interview with the Housekeeping/Laundry Supervisor on 04/03/13 at 5:15 PM revealed the Supervisor was not aware the Laundry Aide was not knowledgeable regarding fire procedures for the laundry area. In addition, the Housekeeping/Laundry Supervisor stated she was not aware of any fire drills that had been conducted in the laundry area for Laundry Room staff. An interview conducted with the Maintenance Director on 04/03/13 at 5:30 PM, revealed the Maintenance Director had not conducted any fire drills in the laundry area for the Laundry Aide.
F 0518	**Train all employees on what to do in an emergency, and carry out announced staff drills.** Based on interview and record review it was determined the facility failed to ensure emergency fire procedures were periodically reviewed with one of three existing staff members. A Laundry Aide was not knowledgeable regarding the procedures to implement in the event there was a fire in the Laundry. The findings include: A review of the facility's Fire Safety Procedure Plan, dated January 2005, revealed if a fire was discovered in the laundry area staff was to pull the nearest fire alarm and fight the fire with a portable fire extinguisher. An interview conducted on 04/03/13 at 10:15 AM, with a Laundry Aide who had been assigned to the Laundry on 04/03/13, revealed the Laundry Aide was not aware of the procedure to take in the event of a fire in the laundry area. The Laundry Aide stated that even though she had participated in a fire drill on the C Wing of the facility, she had not participated in a fire drill in the laundry area. According to the Laundry Aide, during the fire drill on the C Wing, another housekeeping staff person instructed her on what to do during the fire drill because the facility had not trained her on the procedures to take in the event of a fire at the facility. A review of the facility's employee training for fire safety revealed a post test had been completed by the Laundry Aide on 06/26/12 that revealed the Laundry Aide had been trained regarding the facility's general fire procedures; however, it could not be determined that the training included the laundry area. An interview with the Housekeeping/Laundry Supervisor on 04/03/13 at 5:15 PM revealed the Supervisor was not aware the Laundry Aide was not knowledgeable regarding fire procedures for the laundry area. In addition, the Housekeeping/Laundry Supervisor stated she was not aware of any fire drills that had been conducted in the laundry area for Laundry Room staff. An interview conducted with the Maintenance Director on 04/03/13 at 5:30 PM, revealed the Maintenance Director had not conducted any fire drills in the laundry area for the Laundry Aide.
F 0520	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview, record review, and review of facility policy and procedures and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resident abuse were reported to Facility Administration from 02/17/13 to 04/04/13, involving Residents #1, #4, #19, #29, #30, and #31. Interview and record review revealed administrative staff failed to thoroughly investigate/report these allegations of abuse and failed to protect residents. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. (Refer to F223, F225, F226, and F490.) The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Two Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13, and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy and procedure entitled Quality Assurance/Continuous Quality Improvement, with no date, revealed systems should be in place so that problems were prevented from ever occurring. Further review of the policy revealed the primary purposes of the Quality Assurance/Continuous Quality Improvement plan were as follows: 1. To provide a means whereby negative outcomes related to resident care and safety could be identified and resolved through an interdisciplinary approach and effective systems of services and positive care measures rendered, reinforced, and expanded to improve care given. 2. To establish and provide a system whereby a specific process and the documentation relative to it was maintained to support evidence of an ongoing quality assurance/continuous improvement plan, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to nursing home residents. 3. To develop monitoring tools that provide an effective mechanism to assure that each resident received the necessary care and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 4. To assist facilities that provided care to residents to delineate lines of authority, responsibility, and accountability so that opened lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. To provide a centralized, coordinated approach to quality assurance/continuous improvement to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility. The policy further stated all corrective activities would be monitored to determine appropriateness and/or the need for alternative measures. According to the policy/procedure, the Administrator of the facility was ultimately responsible for the quality assurance/continuous improvement program and was also responsible for ensuring the quality assurance/continuous improvement program of the facility was in compliance with federal, state, and local regulatory requirements. Based on interview and record review Immediate Jeopardy was identified on 03/01/13 and on 03/29/13 because of the facility's failure to identify/report/investigate allegations of abuse and for failure to protect residents from further potential abuse. The facility submitted two acceptable Allegations of Compliance (AOCs) to remove Immediate Jeopardy on 03/05/13 and on 04/05/13 that included reeducating all staff, including administrative staff, on abuse reporting, investigating, and protection. In addition, on 04/06/13 and 04/07/13, facility staff was retrained on abuse protocols that included investigation, reporting, and protection of residents. Further, the 03/05/13 AOC stated the facility had reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's social worker approximately two to three months prior when the incident occurred (03/01/13). In addition, the 04/05/13 AOC stated an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, there was no evidence these

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NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520	(continued... from page 52)

plans of action were effective in identifying allegations of abuse and ensuring all allegations were reported/investigated and residents were protected. On 03/29/13, 04/05/13, and 04/09/12, additional allegations of abuse related to Residents #19, #29, #30, and #31 were identified which had not been reported to the appropriate State Agencies, and had not been thoroughly investigated. Review of the investigation logs revealed no entry related to these allegations of abuse. In addition, an interview with Administrator #2 revealed the abuse log was not effective to identify facility failures to report and investigate allegations of abuse and to protect Residents #19, #29, #30, and #31. Per interview, Administrator #2 was not aware of these allegations of abuse. An interview on 04/09/13 at 11:09 AM with the Social Worker/Abuse Coordinator, who was a member of the monthly QA committee and as of 04/08/13 was no longer employed by the facility, revealed she did not have a way to track or a log to review any complaints or allegations related to abuse. She further stated there was no way of knowing what allegations have been made and she was not aware of who was supposed to review these allegations. Further interview revealed she gave any paperwork she had related to the allegations to the Administrator. An interview with Administrator #2 on 04/09/13 at 11:40 AM revealed that prior to 04/04/13 the facility did not have a system for tracking/trending abuse allegations. The Administrator further stated that the last QA meeting was held either on 03/13/13 or 03/14/13. During the meeting, the Administrator stated they did not go into detail about past abuse allegations and he was told that all abuse allegations had been reported/investigated and residents had been protected. The Administrator stated he didn't know why the facility had not identified that other allegations of resident abuse had not been reported/investigated and residents had not been protected. The Administrator stated it took a different set of eyes is all I can say to identify the allegations. The Administrator further stated he did not feel staff was properly trained on how to identify abuse allegations. An interview on 04/04/13 at 3:15 PM, with the Chief Nurse Executive for the Corporation and a Corporate Consultant who was filling in at the facility as the DON, revealed audits conducted as part of the facility's AOCs had not been reviewed through the facility's QA program. ---The facility provided an acceptable AOC on 04/17/13, which alleged removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. Administrator #1, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin.
The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) will visit 20 residents daily with a BIMS score of less than 7 and will speak to the Nurse and CNA (State Registered Nurse Aide) regarding any noted changes to the resident's behavior. In addition, a licensed nurse will complete a head to toe skin assessment for the 20 residents with BIMS score of less than 7, to ensure that no physical signs of abuse are present. The above interviews and skin audits will be placed in a binder called the AOC binder that will be located in the Administrator's office. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Administrator, Director of Nursing, Social Services Director, or Regional Staff will review all resident and staff questionnaires daily for grievances/concerns. Investigations of grievances/concerns will be initiated upon identification. All resident records were reviewed by the Clinical Regional Nurse Consultant on 04/12/13 for documentation regarding abuse, with no new incidents being identified. Ten resident records are being reviewed by Administrative Nurses (Director of Nursing, Staff Development Coordinator, MDS Coordinators, Unit Manager, Assistant Director of Nursing) or Regional Nurse Consultants (Regional Nurse Consultants, Director of Clinical Programs, Chief Nurse Executive) daily to ensure that no other abuse allegations have been documented without reporting. This will continue until the removal of Immediate Jeopardy. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ---Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting twenty (20) interviews daily, seven (7) days a week, of residents with a BIMS of seven (7) or higher related to abuse/neglect. Further interviews and record review revealed the staff had also visited with twenty (20) residents a day, seven (7) days a week, who had a BIMS below seven (7), and had spoken to the Nurse and SRNA regarding any changes in behaviors or signs of abuse. Record review and interview on 04/23/13 at 1:23 PM with the Staff Development Coordinator; at 11:32 AM with the Regional Nurse Consultant; at 11:53 with the Chief Nurse Executive; and at 12:21 PM with the Director of Nursing revealed they had assisted with conducting twenty (20) skin assessments a day, seven (7) days a week, of the residents that were non-interviewable and had not identified any concerns related to physical abuse. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting interviews with twenty (20) staff members a day, seven (7) days a week, regarding their knowledge of the facility's policy on abuse/potential abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**
NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET BEATTYVILLE, KY 41311**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520	(continued... from page 53) Interview on 04/23/13 at 10:35 AM with SRNA #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:05 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #9; at 12:38 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 revealed management staff had spoken with floor staff daily regarding their knowledge of the facility's policy on abuse and if they were aware of any potential abuse situations in the facility. Interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they had met daily, seven days a week, and had reviewed all resident and staff questionnaires that had been conducted to identify any concerns. No concerns had been identified. Record review and interview on 04/23/13 at 1:46 PM with the Clinical Regional Nurse Consultant revealed she had conducted chart audits on 100% of the charts in the facility in an effort to identify potential abuse, which may have been documented but not reported. In addition, the Clinical Regional Nurse Consultant stated she had assisted with ten (10) chart audits a day, seven days a week, and had not identified any concerns related to abuse. Record review and interview on 04/23/13 at 12:21 PM with the Director of Nursing; at 1:23 PM with the Staff Development Coordinator; and at 11:32 AM with the Regional Nurse Consultant revealed they were conducting ten (10) chart audits a day, seven days a week, to review for signs of abuse that were reported and no concerns were identified. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis.
F 0520	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview, record review, and review of facility policy and procedures and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resident abuse were reported to Facility Administration from 02/17/13 to 04/04/13, involving Residents #1, #4, #19, #29, #30, and #31. Interview and record review revealed administrative staff failed to thoroughly investigate/report these allegations of abuse and failed to protect residents. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. (Refer to F223, F225, F226, and F490.) The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Two Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13, and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy and procedure entitled Quality Assurance/Continuous Quality Improvement, with no date, revealed systems should be in place so that problems were prevented from ever occurring. Further review of the policy revealed the primary purposes of the Quality Assurance/Continuous Quality Improvement plan were as follows: 1. To provide a means whereby negative outcomes related to resident care and safety could be identified and resolved through an interdisciplinary approach and effective systems of services and positive care measures rendered, reinforced, and expanded to improve care given. 2. To establish and provide a system whereby a specific process and the documentation relative to it was maintained to support evidence of an ongoing quality assurance/continuous improvement plan, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to nursing home residents. 3. To develop monitoring tools that provide an effective mechanism to assure that each resident received the necessary care and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 4. To assist facilities that provided care to residents to delineate lines of authority, responsibility, and accountability so that opened lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. To provide a centralized, coordinated approach to quality assurance/continuous improvement to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility. The policy further stated all corrective activities would be monitored to determine appropriateness and/or the need for alternative measures. According to the policy/procedure, the Administrator of the facility was ultimately responsible for the quality assurance/continuous improvement program and was also responsible for ensuring the quality assurance/continuous improvement program of the facility was in compliance with federal, state, and local regulatory requirements. Based on interview and record review Immediate Jeopardy was identified on 03/01/13 and on 03/29/13 because of the facility's failure to identify/report/investigate allegations of abuse and for failure to protect residents from further potential abuse. The facility submitted two acceptable Allegations of Compliance (AOCs) to remove Immediate Jeopardy on 03/05/13 and on 04/05/13 that included reeducating all staff, including administrative staff, on abuse reporting, investigating, and protection. In addition, on 04/06/13 and 04/07/13, facility staff was retrained on abuse protocols that included investigation, reporting, and protection of residents. Further, the 03/05/13 AOC stated the facility had reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's social worker approximately two to three months prior when the incident occurred (03/01/13). In addition, the 04/05/13 AOC stated an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, there was no evidence these plans of action were effective in identifying allegations of abuse and ensuring all allegations were reported/investigated and residents were protected. On 03/29/13, 04/05/13, and 04/09/12, additional allegations of abuse related to Residents #19, #29, #30, and #31 were identified which had not been reported to the appropriate State Agencies, and had not been thoroughly investigated. Review of the investigation logs revealed no entry related to these allegations of abuse. In addition, an interview with Administrator #2 revealed the abuse log was not effective to identify facility failures to report and investigate allegations of abuse and to protect Residents #19, #29, #30, and #31. Per interview, Administrator #2 was not aware of these allegations of abuse. An interview on 04/09/13 at 11:09 AM with the Social Worker/Abuse Coordinator, who was a member of the monthly QA committee and as of 04/08/13 was no longer employed by the facility, revealed she did not have a way to track or a log to review any complaints or allegations related to abuse. She further stated there was no way of knowing what allegations have been made and she was not aware of who was supposed to review these allegations. Further interview revealed she gave any paperwork she had related to the allegations to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185337	A. BUILDING ______ B. WING _____	**04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520	(continued... from page 54) Administrator. An interview with Administrator #2 on 04/09/13 at 11:40 AM revealed that prior to 04/04/13 the facility did not have a system for tracking/trending abuse allegations. The Administrator further stated that the last QA meeting was held either on 03/13/13 or 03/14/13. During the meeting, the Administrator stated they did not go into detail about past abuse allegations and he was told that all abuse allegations had been reported/investigated and residents had been protected. The Administrator stated he didn't know why the facility had not identified that other allegations of resident abuse had not been reported/investigated and residents had not been protected. The Administrator stated it took a different set of eyes is all I can say to identify the allegations. The Administrator further stated he did not feel staff was properly trained on how to identify abuse allegations. An interview on 04/04/13 at 3:15 PM, with the Chief Nurse Executive for the Corporation and a Corporate Consultant who was filling in at the facility as the DON, revealed audits conducted as part of the facility's AOCs had not been reviewed through the facility's QA program. ---The facility provided an acceptable AOC on 04/17/13, which alleged removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. Administrator #1, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) will visit 20 residents daily with a BIMS score of less than 7 and will speak to the Nurse and CNA (State Registered Nurse Aide) regarding any noted changes to the resident's behavior. In addition, a licensed nurse will complete a head to toe skin assessment for the 20 residents with BIMS score of less than 7, to ensure that no physical signs of abuse are present. The above interviews and skin audits will be placed in a binder called the AOC binder that will be located in the Administrator's office. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Administrator, Director of Nursing, Social Services Director, or Regional Staff will review all resident and staff questionnaires daily for grievances/concerns. Investigations of grievances/concerns will be initiated upon identification. All resident records were reviewed by the Clinical Regional Nurse Consultant on 04/12/13 for documentation regarding abuse, with no new incidents being identified. Ten resident records are being reviewed by Administrative Nurses (Director of Nursing, Staff Development Coordinator, MDS Coordinators, Unit Manager, Assistant Director of Nursing) or Regional Nurse Consultants (Regional Nurse Consultants, Director of Clinical Programs, Chief Nurse Executive) daily to ensure that no other abuse allegations have been documented without reporting. This will continue until the removal of Immediate Jeopardy. The Chief Operating Officer and Chief Nursing Executive completed a review of all allegations of abuse by 04/10/13 to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. The Administrator will continue to report any allegations of abuse, neglect, or misappropriation as identified. The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ---Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting twenty (20) interviews daily, seven (7) days a week, of residents with a BIMS of seven (7) or higher related to abuse/neglect. Further interviews and record review revealed the staff had also visited with twenty (20) residents a day, seven (7) days a week, who had a BIMS below seven (7), and had spoken to the Nurse and SRNA regarding any changes in behaviors or signs of abuse. Record review and interview on 04/23/13 at 1:23 PM with the Staff Development Coordinator; at 11:32 AM with the Regional Nurse Consultant; at 11:53 with the Chief Nurse Executive; and at 12:21 PM with the Director of Nursing revealed they had assisted with conducting twenty (20) skin assessments a day, seven (7) days a week, of the residents that were non-interviewable and had not identified any concerns related to physical abuse. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting interviews with twenty (20) staff members a day, seven (7) days a week, regarding their knowledge of the facility's policy on abuse/potential abuse. Interview on 04/23/13 at 10:35 AM with SRNA #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:05 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #9; at 12:38 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 revealed management staff had spoken with floor staff daily regarding their knowledge of the facility's policy on abuse and if they were aware of any potential abuse situations in the facility. Interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they had met daily, seven days a week, and had reviewed all resident and staff questionnaires that had been conducted to identify any concerns. No concerns had been identified. Record review and interview on 04/23/13 at 1:46 PM with the Clinical Regional Nurse Consultant revealed she had conducted chart audits on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

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F 0520	(continued... from page 55) 100% of the charts in the facility in an effort to identify potential abuse, which may have been documented but not reported. In addition, the Clinical Regional Nurse Consultant stated she had assisted with ten (10) chart audits a day, seven days a week, and had not identified any concerns related to abuse. Record review and interview on 04/23/13 at 12:21 PM with the Director of Nursing; at 1:23 PM with the Staff Development Coordinator; and at 11:32 AM with the Regional Nurse Consultant revealed they were conducting ten (10) chart audits a day, seven days a week, to review for signs of abuse that were reported and no concerns were identified. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis.
F 0520	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview, record review, and review of facility policy and procedures and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resident abuse were reported to Facility Administration from 02/17/13 to 04/04/13, involving Residents #1, #4, #19, #29, #30, and #31. Interview and record review revealed administrative staff failed to thoroughly investigate/report these allegations of abuse and failed to protect residents. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. (Refer to F223, F225, F226, and F490.) The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Two Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13, and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy and procedure entitled Quality Assurance/Continuous Quality Improvement, with no date, revealed systems should be in place so that problems were prevented from ever occurring. Further review of the policy revealed the primary purposes of the Quality Assurance/Continuous Quality Improvement plan were as follows: 1. To provide a means whereby negative outcomes related to resident care and safety could be identified and resolved through an interdisciplinary approach and effective systems of services and positive care measures rendered, reinforced, and expanded to improve care given. 2. To establish and provide a system whereby a specific process and the documentation relative to it was maintained to support evidence of an ongoing quality assurance/continuous improvement plan, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to nursing home residents. 3. To develop monitoring tools that provide an effective mechanism to assure that each resident received the necessary care and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 4. To assist facilities that provided care to residents to delineate lines of authority, responsibility, and accountability so that opened lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. To provide a centralized, coordinated approach to quality assurance/continuous improvement to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility. The policy further stated all corrective activities would be monitored to determine appropriateness and/or the need for alternative measures. According to the policy/procedure, the Administrator of the facility was ultimately responsible for the quality assurance/continuous improvement program and was also responsible for ensuring the quality assurance/continuous improvement program of the facility was in compliance with federal, state, and local regulatory requirements. Based on interview and record review Immediate Jeopardy was identified on 03/01/13 and on 03/29/13 because of the facility's failure to identify/report/investigate allegations of abuse and for failure to protect residents from further potential abuse. The facility submitted two acceptable Allegations of Compliance (AOCs) to remove Immediate Jeopardy on 03/05/13 and on 04/05/13 that included reeducating all staff, including administrative staff, on abuse reporting, investigating, and protection. In addition, on 04/06/13 and 04/07/13, facility staff was retrained on abuse protocols that included investigation, reporting, and protection of residents. Further, the 03/05/13 AOC stated the facility had reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's social worker approximately two to three months prior when the incident occurred (03/01/13). In addition, the 04/05/13 AOC stated an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, there was no evidence these plans of action were effective in identifying allegations of abuse and ensuring all allegations were reported/investigated and residents were protected. On 03/29/13, 04/05/13, and 04/09/12, additional allegations of abuse related to Residents #19, #29, #30, and #31 were identified which had not been reported to the appropriate State Agencies, and had not been thoroughly investigated. Review of the investigation logs revealed no entry related to these allegations of abuse. In addition, an interview with Administrator #2 revealed the abuse log was not effective to identify facility failures to report and investigate allegations of abuse and to protect Residents #19, #29, #30, and #31. Per interview, Administrator #2 was not aware of these allegations of abuse. An interview on 04/09/13 at 11:09 AM with the Social Worker/Abuse Coordinator, who was a member of the monthly QA committee and as of 04/08/13 was no longer employed by the facility, revealed she did not have a way to track or a log to review any complaints or allegations related to abuse. She further stated there was no way of knowing what allegations have been made and she was not aware of who was supposed to review these allegations. Further interview revealed she gave any paperwork she had related to the allegations to the Administrator. An interview with Administrator #2 on 04/09/13 at 11:40 AM revealed that prior to 04/04/13 the facility did not have a system for tracking/trending abuse allegations. The Administrator further stated that the last QA meeting was held either on 03/13/13 or 03/14/13. During the meeting, the Administrator stated they did not go into detail about past abuse allegations and he was told that all abuse allegations had been reported/investigated and residents had been protected. The Administrator stated he didn't know why the facility had not identified that other allegations of resident abuse had not been reported/investigated and residents had not been protected. The Administrator stated it took a different set of eyes is all I can say to identify the allegations. The Administrator further stated he did not feel staff was properly trained on how to identify abuse allegations. An interview on 04/04/13 at 3:15 PM, with the Chief Nurse Executive for the Corporation and a Corporate Consultant who was filling in at the facility as the DON, revealed audits conducted as part of the facility's AOCs had not been reviewed through the facility's QA program. ---The facility provided an acceptable AOC on 04/17/13, which alleged removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13,

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F 0520	(continued... from page 56) the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. Administrator #1, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) will visit 20 residents daily with a BIMS score of less than 7 and will speak to the Nurse and CNA (State Registered Nurse Aide) regarding any noted changes to the resident's behavior. In addition, a licensed nurse will complete a head to toe skin assessment for the 20 residents with BIMS score of less than 7, to ensure that no physical signs of abuse are present. The above interviews and skin audits will be placed in a binder called the AOC binder that will be located in the Administrator's office. Findings of signs and symptoms of potential abuse will be reported immediately to the Charge Nurse. The Charge Nurse will remove the alleged perpetrator, if known, from the resident care area immediately. The Charge Nurse will notify the Administrator. The Administrator will immediately initiate an investigation, and report to the Office of Inspector General, any allegations of abuse or injuries of unknown origin. The Administrator, Director of Nursing, Social Services Director, or Regional Staff will review all resident and staff questionnaires daily for grievances/concerns. Investigations of grievances/concerns will be initiated upon identification. All resident records were reviewed by the Clinical Regional Nurse Consultant on 04/12/13 for documentation regarding abuse, with no new incidents being identified. 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The Chief Operating Officer or Regional Vice President of Operations will complete a daily review of abuse allegations, grievance reports, incident reports, and daily resident interviews to ensure appropriate protection, reporting, and investigations of abuse allegations. The Chief Nurse Executive or Regional Clinical Consultant will complete a daily onsite visit to review skin assessments to ensure appropriate protection, reporting to the Office of Inspector General, and investigations of allegations of abuse. Daily reviews will continue until the removal of Immediate Jeopardy. The Administrator, Director of Nursing, and Social Services Director will review and discuss all abuse investigations daily to ensure that the resident is protected, the perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and a thorough investigation is completed. The Administrator will maintain an abuse investigation log that will include documentation of the following: ensured protection of residents, perpetrator is removed from resident care area, reports to the Inspector General are filed timely, and thorough investigation is completed. The Administrator and one of the following: Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will review the abuse investigation to ensure protection of the resident, that the perpetrator was removed from the resident care area, reports to the Inspector General were filed timely, and a thorough investigation has been completed. This will occur daily until removal of Immediate Jeopardy. ---Based on observation, interview, record review, and review of the facility's Allegation of Compliance (AOC), the State Survey Agency validated the AOC as follows: Interview with the Chief Operating Officer, on 04/23/13 at 2:12 PM, revealed he performed a search of the Administrator's office on 04/11/13 and 04/12/13 and identified six (6) files that had not been thoroughly investigated nor reported, that were submitted to the appropriate State Agencies on 04/11/13 and 04/12/13. Record review and interview on 04/23/13 at 11:32 AM with the Regional Nurse Consultant; at 11:53 AM with the Chief Nurse Executive; at 2:38 PM with Administrator #2; at 10:35 AM with the Director of Admissions; at 12:09 PM with the Quality of Life Director; at 12:21 PM with the Director of Nursing; at 12:38 PM with the Interim Social Services Director; at 12:45 PM with the Rehabilitation Service Manager; at 1:04 PM with the Dietary Manager; at 1:16 PM with the Housekeeping Manager; and at 1:23 PM with the Staff Development Coordinator revealed they had assisted with conducting twenty (20) interviews daily, seven (7) days a week, of residents with a BIMS of seven (7) or higher related to abuse/neglect. Further interviews and record review revealed the staff had also visited with twenty (20) residents a day, seven (7) days a week, who had a BIMS below seven (7), and had spoken to the Nurse and SRNA regarding any changes in behaviors or signs of abuse. Record review and interview on 04/23/13 at 1:23 PM with the Staff Development Coordinator; at 11:32 AM with the Regional Nurse Consultant; at 11:53 with the Chief Nurse Executive; and at 12:21 PM with the Director of Nursing revealed they had assisted with conducting twenty (20) skin assessments a day, seven (7) days a week, of the residents that were non-interviewable and had not identified any concerns related to physical abuse. 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Interview on 04/23/13 at 10:35 AM with SRNA #8; at 10:53 AM with Housekeeper #4; at 11:03 AM with Registered Nurse #5; at 11:16 AM with Housekeeper #5; at 11:27 AM with Licensed Practical Nurse #4; at 11:37 AM with SRNA #5; at 11:45 AM with Dietary Aide #1; at 11:54 AM with Dietary Aide #2; at 12:05 PM with SRNA #7; at 12:12 PM with Registered Nurse #4; at 12:20 PM with SRNA #12; at 12:28 PM with SRNA #9; at 12:38 PM with SRNA #1; at 12:49 PM with Certified Medication Aide #1; at 12:56 PM with Certified Medication Aide #6; at 1:09 PM with SRNA #1; at 1:17 PM with Maintenance Worker #1; at 1:41 PM with Laundry Worker #1; and at 1:54 PM with Activity Assistant #1 revealed management staff had spoken with floor staff daily regarding their knowledge of the facility's policy on abuse and if they were aware of any potential abuse situations in the facility. Interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they had met daily, seven days a week, and had reviewed all resident and staff questionnaires that had been conducted to identify any concerns. No concerns had been identified. Record review and interview on 04/23/13 at 1:46 PM with the Clinical Regional Nurse Consultant revealed she had conducted chart audits on 100% of the charts in the facility in an effort to identify potential abuse, which may have been documented but not reported. In addition, the Clinical Regional Nurse Consultant stated she had assisted with ten (10) chart audits a day, seven days a week, and had not identified any concerns related to abuse. Record review and interview on 04/23/13 at 12:21 PM with the Director of Nursing; at 1:23 PM with the Staff Development Coordinator; and at 11:32 AM with the Regional Nurse Consultant revealed they were conducting ten (10) chart audits a day, seven days a week, to review for signs of abuse that were reported and no concerns were identified. Interview with the Chief Operating Officer on 04/23/13 at 2:12 PM and the Chief Nurse Executive at 11:53 AM revealed, by 04/10/13, they had completed a review of all allegations of abuse received by the facility and no concerns were identified. Further interview with the Chief Operating Officer revealed he had assisted in completing daily reviews, seven (7) days a week, of abuse allegations, grievance reports, incident reports, and daily resident interviews with no concerns identified. Interview with the Chief Nurse Executive on 04/23/13 at 11:53 AM and the Regional Nurse Consultant at 11:32 AM revealed they were reviewing all daily skin assessments onsite. Record review and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185337**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/09/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE COUNTY CARE & REHABILITATION CENTER	**246 EAST MAIN STREET BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520	(continued... from page 57) interview on 04/23/13 at 2:38 PM with Administrator #2; at 12:21 PM with the Director of Nursing; and at 12:38 PM with the Interim Social Services Director revealed they were meeting on numerous occasions daily to review any abuse investigations that were reported. The Administrator stated he utilized an abuse investigation log daily to keep track of all abuse allegations to ensure they were investigated, the residents were protected, and that the allegations had been reported timely to the appropriate State Agencies. Interview with the Chief Nurse Executive on 04/22/13 at 2:15 PM revealed she assists in reviewing the abuse investigation log on a daily, seven (7) days a week, basis.
F 0520	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview, record review, and review of facility policy and procedures and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. Six allegations of resident abuse were reported to Facility Administration from 02/17/13 to 04/04/13, involving Residents #1, #4, #19, #29, #30, and #31. Interview and record review revealed administrative staff failed to thoroughly investigate/report these allegations of abuse and failed to protect residents. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. (Refer to F223, F225, F226, and F490.) The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Two Immediate Jeopardy situations were identified on 03/01/13 and 03/24/13 related to abuse. The Immediate Jeopardy was determined to exist on 02/17/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226) and 42 CFR 483.75 Administration (F490 and F520), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223, F225, and F226). The facility was notified of the Immediate Jeopardy on 03/01/13 and 03/29/13, and was informed on 04/09/13 the Immediate Jeopardy was ongoing. The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/17/13 with the facility alleging removal of the Immediate Jeopardy on 04/17/13. The State Survey Agency (SSA) verified removal of the Immediate Jeopardy on 04/22-04/23/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 - S/S D and F225 and F226 - S/S E) and 42 CFR 483.75 Administration (F490 and F520 - S/S E) while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy and procedure entitled Quality Assurance/Continuous Quality Improvement, with no date, revealed systems should be in place so that problems were prevented from ever occurring. Further review of the policy revealed the primary purposes of the Quality Assurance/Continuous Quality Improvement plan were as follows: 1. To provide a means whereby negative outcomes related to resident care and safety could be identified and resolved through an interdisciplinary approach and effective systems of services and positive care measures rendered, reinforced, and expanded to improve care given. 2. To establish and provide a system whereby a specific process and the documentation relative to it was maintained to support evidence of an ongoing quality assurance/continuous improvement plan, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to nursing home residents. 3. To develop monitoring tools that provide an effective mechanism to assure that each resident received the necessary care and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 4. To assist facilities that provided care to residents to delineate lines of authority, responsibility, and accountability so that opened lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis. 5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results. 6. To provide a centralized, coordinated approach to quality assurance/continuous improvement to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility. The policy further stated all corrective activities would be monitored to determine appropriateness and/or the need for alternative measures. According to the policy/procedure, the Administrator of the facility was ultimately responsible for the quality assurance/continuous improvement program and was also responsible for ensuring the quality assurance/continuous improvement program of the facility was in compliance with federal, state, and local regulatory requirements. Based on interview and record review Immediate Jeopardy was identified on 03/01/13 and on 03/29/13 because of the facility's failure to identify/report/investigate allegations of abuse and for failure to protect residents from further potential abuse. The facility submitted two acceptable Allegations of Compliance (AOCs) to remove Immediate Jeopardy on 03/05/13 and on 04/05/13 that included reeducating all staff, including administrative staff, on abuse reporting, investigating, and protection. In addition, on 04/06/13 and 04/07/13, facility staff was retrained on abuse protocols that included investigation, reporting, and protection of residents. Further, the 03/05/13 AOC stated the facility had reviewed all incidents and investigations that occurred from June 2012 through the present time, with no concerns. However, during an interview with Resident #29 on 04/05/13, the resident stated he/she had reported an allegation of abuse to the facility's social worker approximately two to three months prior when the incident occurred (03/01/13). In addition, the 04/05/13 AOC stated an abuse investigation log was to be maintained by the Administrator to track/trend all allegations of abuse. However, there was no evidence these plans of action were effective in identifying allegations of abuse and ensuring all allegations were reported/investigated and residents were protected. On 03/29/13, 04/05/13, and 04/09/12, additional allegations of abuse related to Residents #19, #29, #30, and #31 were identified which had not been reported to the appropriate State Agencies, and had not been thoroughly investigated. Review of the investigation logs revealed no entry related to these allegations of abuse. In addition, an interview with Administrator #2 revealed the abuse log was not effective to identify facility failures to report and investigate allegations of abuse and to protect Residents #19, #29, #30, and #31. Per interview, Administrator #2 was not aware of these allegations of abuse. An interview on 04/09/13 at 11:09 AM with the Social Worker/Abuse Coordinator, who was a member of the monthly QA committee and as of 04/08/13 was no longer employed by the facility, revealed she did not have a way to track or a log to review any complaints or allegations related to abuse. She further stated there was no way of knowing what allegations have been made and she was not aware of who was supposed to review these allegations. Further interview revealed she gave any paperwork she had related to the allegations to the Administrator. An interview with Administrator #2 on 04/09/13 at 11:40 AM revealed that prior to 04/04/13 the facility did not have a system for tracking/trending abuse allegations. The Administrator further stated that the last QA meeting was held either on 03/13/13 or 03/14/13. During the meeting, the Administrator stated they did not go into detail about past abuse allegations and he was told that all abuse allegations had been reported/investigated and residents had been protected. The Administrator stated he didn't know why the facility had not identified that other allegations of resident abuse had not been reported/investigated and residents had not been protected. The Administrator stated it took a different set of eyes is all I can say to identify the allegations. The Administrator further stated he did not feel staff was properly trained on how to identify abuse allegations. An interview on 04/04/13 at 3:15 PM, with the Chief Nurse Executive for the Corporation and a Corporate Consultant who was filling in at the facility as the DON, revealed audits conducted as part of the facility's AOCs had not been reviewed through the facility's QA program. ---The facility provided an acceptable AOC on 04/17/13, which alleged removal of Immediate Jeopardy on 04/17/13 based on the following: On 04/11/13 and 04/12/13, the Chief Operating Officer performed a document search of the Administrator's office and computer for any files related to allegations of abuse, misappropriation, or neglect. There were six files identified, which had not been reported to appropriate State Agencies and had not been thoroughly investigated, in which the initial reports were submitted on 04/11/13 and 04/12/13 to the appropriate State Agencies. Administrator #1, Director of Nursing, Interim Social Services Director, Department Managers (MDS Coordinators, Dietary Manager, Housekeeping Director, Social Service Director, Administrator, Director of Nursing, Business Office Manager, Staffing Coordinator, Plant Operations Director, Unit Managers, Assistant Director of Nursing, Admissions Director, Activities Director, Medical Records Director, Rehabilitation Manager) or Regional staff (Clinical Program Director, Regional Nurse Consultant, Signature Care Consultant, Internal Audit Director, Chief Nurse Executive, Clinical Reimbursement Consultant, Director of Medical Review) conducted 20 interviews daily which were initiated on 04/13/13 with residents who have a BIMS score of 7 or above, to ensure residents feel protected without any evidence of abuse, neglect, or misappropriation. Findings of signs and symptoms of potential abuse

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NAME OF PROVIDER OF SUPPLIER **LEE COUNTY CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **246 EAST MAIN STREET** **BEATTYVILLE, KY 41311**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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