STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185093	A. BUILDING _____ B. WING _____	**05/02/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, GLASGOW	**109 HOMEWOOD BLVD. GLASGOW, KY 42141**

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 review of video recordings, interviews, record reviews and review of the facility's Abuse/Neglect and Misappropriation of Resident Property policy and procedure, it was determined the facility failed to ensure one (1) of five (5) sampled residents (Resident #1), was free from abuse. The facility failed to have an effective system in place to ensure residents were free from abusive treatment by staff; and, failed to ensure staff reported the observed mistreatment of [REDACTED]. The facility's Certified Nurse Aides (CNA) were video recorded by a Nanny Cam placed in Resident #1's and #2's shared room by a family member. The video recordings revealed the CNAs, who were providing care to Resident #1, were displaying inappropriate behaviors. The CNAs were video recorded on different dates, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing their finger at the resident in a threatening manner just inches from his/her face after care had been provided. The facility's failure to ensure residents were free from abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist on 01/15/14. The findings include: Review of the facility's policy and procedure, titled Policy Regarding Abuse/Neglect and Misappropriation of Resident Property, dated 09/24/09, revealed the policy and procedures shall be in place to prevent resident abuse. The policy defined the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish as abuse. The policy listed controlling behavior through corporal punishment as physical abuse. Mental abuse was listed as including, but not limited to, humiliation, harassment and threats of punishment or deprivation. Record review revealed the facility admitted Resident #1 on 08/13/09 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/20/14, revealed the facility staff's assessment of Resident #1's cognitive status was severely impaired and the resident required extensive assistance with transfers, hygiene and bathing and was incontinent at times of bowel and bladder. In addition, the resident had behaviors of being resistive to care at times. An attempt on 04/15/14 at 9:00 AM to interview Resident #1 was unsuccessful due to the Resident's severe cognitive impairment. Review of the video recording, on 04/14/14, revealed the following: 1. On 01/10/14 at 10:02 PM, two (2) CNAs provided care for Resident#1 (one on the side of the bed by the door and the other one was on the side by the window). Resident #1 was resistive and attempting to pinch the CNA nearest the window of the room. The CNA, not smiling, appeared to be saying something to Resident #1 and then pointed her finger in Resident #1's face in a threatening manner 2. On 01/11/14 at 4:10 AM, two (2) CNAs entered the resident's room, closed the hall door and while standing in view of Resident #1 at the foot of Resident #1's bed, one of the CNAs bent over and bit or kissed the buttocks of the other CNA. The CNAs then provided care to Resident #1. 3. On 01/15/14 at 10:56 PM, two (2) CNAs provided care to Resident #1 and when the resident was resistive, his/her hands were restrained on the resident's chest and one of the CNAs (nearest the window) moved to the head of the bed leaning forward into the resident's face in a threatening manner. 4. On 01/17/14 at 4:00 AM, two (2) CNAs provided care to Resident #1 and one (1) of the CNAs (nearest the door) picked up a banana off the resident's bed side table and made an inappropriate sexual gesture like she was going to stick the banana between the resident's legs. 5. On 02/03/14 at 1:18 AM, two (2) CNAs provided care to Resident #1. The resident was kicking out and being resistive. One of the CNAs was restraining Resident #1's hands at the wrist. The CNAs finished care and moved to exit from the room when one of the CNAs (nearest the door) turned and returned to the head of the resident's bed pointing a finger at the resident's face and then reached toward the resident's face, leaving her hands in the resident's face for several seconds. The video did not reveal where the CNA's hands went. 6. On 02/03/14 at 4:21 AM, two (2) CNAs entered the resident's room and stood over Resident #1. One CNA (nearest the door) showed the other CNA (nearest the window) her left breast and the other CNA (nearest the window) performed a breast exam on herself in front of Resident #1. Both CNAs then stood over Resident #1 and talked on their cell phones. The CNAs left the room without providing any care for Resident #1. 7. On 03/12/14 at 9:00 PM, two (2) CNAs entered the resident's room. Resident #1 repeatedly pushed the cover back from his/her face and one (1) of the CNAs (nearest the window) flipped the cover back over the resident's face five (5) different times. The CNA pointed a finger near the resident's face and then made a taunting gesture of holding her hands by her ears while waving her fingers. Interview with a family member of Resident #1, on 04/14/14 at 9:45 AM, revealed she had placed a Nanny Cam in the room on 01/10/14 to monitor Resident #1's care after facial bruising was identified to Resident #1's face the first week of January. She further stated the facility had determined the bruising was self-inflicted; however, the family member was certain the bruising was not self-inflicted. Interview with the DCBS Representative, on 04/17/14 at 8:30 AM, revealed she had been to the facility on [DATE] in conjunction with an investigator from the OAG office as the family had taken the video recordings to the OAG. She stated interviews were conducted and schedules and assignment sheets were used to identify which CNAs were providing care on the days in question. The CNAs were identified as CNA #1, CNA #2 and CNA #3. Attempts to contact CNA #1 and CNA #3 on 04/16/14 were unsuccessful because their telephone numbers were disconnected. An interview by phone with CNA #2 was conducted on 04/21/14 at 12:15 PM. CNA #2 revealed she had been suspended and questioned about rough handling of Resident #1. CNA #2 stated she had told the Administrator she did not do it (treat the resident roughly). Interview with the Administrator and Director of Nursing (DON), on 04/14/14 at 3:15 PM, revealed the facility was made aware of the allegation on 03/19/14 when the OAG Investigator and a DCBS Representative were at the facility. The Administrator stated he was told by the DCBS Representative to suspend three (3) people that included CNA #1, CNA #2 and CNA #3. The Administrator stated he was not informed of any details of the allegation at the time and was told by DCBS the facility could not conduct an investigation. The Administrator stated on 04/08/14, the OAG Investigator revealed eight (8) to ten (10) video clips to the Administrator. The Administrator stated the OAG Investigator stated the CNAs' behavior was unprofessional and poor technique but did not rise to criminal. The Administrator felt one of the videos could have been rough handling and that CNA #1 was terminated. He further stated the facility reported her to the Nurse Aide Abuse Registry. Further interview revealed the Administrator and DON stated there had not been any allegations of mistreatment of [REDACTED]. **The facility implemented the following actions to remove the Immediate Jeopardy: On 03/19/14, the facility suspended and then terminated CNAs #1, #2, #3 and #4. CNA #1 was reported to the Nurse Aide Abuse Registry by the Administrator. On 04/21/14, the Regional Nurse provided oversight as Unit Managers assisted by other licensed staff (total of ten) and the RN Supervisor conducted physical assessments for signs/symptoms of possible abuse on all residents including Resident #1; no injuries were found. The care plans for Resident #1 were reviewed and updated with focus on interventions specific to the resident's behaviors. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. On 04/22/14, the Regional Nurse in-serviced the Administrator and Director of Nursing regarding the facility's abuse/neglect policy. Together they reviewed and revised the policy to include

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 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) specific assessment of non-interviewable residents for potential abuse during investigations. The Medical Director was informed of the policy revision. Beginning 04/22/14, all facility employees were inserviced regarding the revision in the policy and employees on leave or unavailable would have the inservice prior to working their next shift; this was completed on 04/23/14. Inservice training was provided to licensed staff by the DON, RNs and Unit Managers and Nurse Supervisors on recognizing and managing Alzheimer type dementia and emphasized the nurses' and CNAs' understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. This was initiated on 03/20/14 and completed on 03/21/14. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy including the types of abuse and interviewing residents. An additional four (4) weeks of monitoring was added following the 04/22/14 revision that included the assessment of non-interviewable residents for potential signs and symptoms of abuse. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Ten (10) random care plans will be reviewed weekly for six (6) weeks by the RN/Unit Managers for appropriate interventions related to specific behavior care plan. The monitors will be completed 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The State Survey Agency validated the Corrective action taken by the facility as follows: Record review for Resident #1 and Resident #2, on 05/01/14, revealed Resident #1 and Resident #2 were assessed by their physician on 03/20/14 and no new orders were given. On 05/01/14, record reviews for Residents #3, #4 and #5 revealed they had been assessed for injuries of unknown injuries and none were found. RN Unit Managers and Supervisors had assessed them. Interview with RN #6 on 05/01/14 at 11:45 AM revealed she and other Unit Managers had completed skin assessments on all residents in the facility on 04/23/14. Review of the inservice logs, on 05/01/14, revealed the Administrator and Director of Nursing were inserviced by the Regional Nurse related to the Policy Regarding Abuse/Neglect and Misappropriation of Resident Property. Interview with the Administrator and Director of Nursing on 05/01/14 at 10:00 AM verified the inservicing was completed. Review of the policy revision for the Abuse/Neglect and Misappropriation of Resident property, on 05/01/14, verified the revision regarding the assessment of non-interviewable patients for potential abuse during investigations. Review on 05/01/14 of the inservice logs, dated 04/22/14 and 04/23/14, revealed all staff was inserviced related to the revision of the policy on 04/23/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff from different shifts to include five (5) LPNs, an RN and eight (8) CNAs revealed the in-servicing had been provided by the DON, RNs/Unit Managers and Nurse Supervisors for Licensed Nurses and CNAs on Recognizing and Managing Alzheimer's Type Dementia and was completed on 03/21/14. Review on 05/01/14 of inservice logs dated 03/22/14 and 03/23/14, revealed all staff was provided in-service training by the DON, RNs/Unit Managers and Nurse Supervisors on Caregiver Stress and Burnout and was completed on 03/22/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff which included five (5) LPNs, an RN and eight (8) CNAs from all shifts, revealed the inservicing had been provided. On 05/01/14 at 11:35 AM, CNA #10 verified through interview that she had received the inservice training by the DON and Unit Manager. The inservice training included the revision of the abuse/neglect policy which included the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:40 AM, LPN #2 verified through interview that she had received the inservice training by the DON. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview at 11:45 on 05/01/14 with RN #2 revealed she had received inservice training by the DON and she had also provided some of the training to the CNAs. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:05 PM and interview with LPN #3 revealed the DON had provided inservice training on the abuse/neglect policy changes, the types of abuse, stress and staff burnout and managing behaviors of residents with Alzheimer's type behaviors. Care plans for residents with behaviors were also included in the training. An interview on 05/01/14 at 12:05 PM with CNA #11 revealed she had been provided inservice training by the Unit Manager. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. Interview with CNAs #12 and #13 on 05/01/14 at 12:10 PM revealed they had received lots of inservicing by the DON and Unit Managers that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:27 PM CNA #14 revealed in interview that she had received inservice training by the Administrative Nurses related to burnout, behaviors of residents, the changes in the abuse policy including residents that were not interviewable. Interview with CNA #15 on 05/01/14 at 12:45 PM revealed she had been provided inservice training by a nurse and the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:48 PM, an interview with LPN #5 revealed she had been provided numerous inservice trainings recently that included the policy, resident behaviors and appropriate interventions, staff burnout and what to do. Review of inservice records revealed inservice training had been provided to the DON, RNs, Unit Managers and Clinical Social Workers by the Regional Nurse and Regional Director of Social Service related to Care Planning that covered ensuring interventions related to resident behaviors were care planned as needed. Interviews on 05/01/14 (between 11:15 AM and 4:00 PM) with the DON, RN, Unit Managers and three (3) Licensed Social Workers revealed they had been provided the inservicing which was completed on 04/23/14. Interview on 05/01/14 at 11:15 AM with the Social Service Director revealed she had received inservice training from the Regional Nurse and Regional Director of Social Service related to resident behavior care plans on 04/24/14. The Social Service Director stated she had also received the inservice training that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:45 AM, an interview with RN #2 revealed she had received inservice training by the Regional Director of Social Service related to resident care plans for behaviors of residents and she had received training by the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview with LPN #2 on 05/01/14 at 11:40 AM revealed she had received inservice training by the Regional Nurse and Regional Director of Social Service on 04/24/14. The training was related to resident care plans for residents with behaviors. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy and additional four (4) weeks following the 04/22/14 revision. This will be completed by 05/30/14. On 05/01/14, Quality Assurance Monitors dated for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14, 04/22/14 and 04/29/14 were reviewed by the Survey Agency and verified as being completed. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Review of documented interviews for the weeks of 03/23/14, 04/01/14, 04/15/14, 04/22/14 and 04/29/14 were verified completed. Review of the Quality Assurance Monitors were reviewed by the State Survey Agency on 05/01/14 and included the interviews of fifteen (15) CNAs and five (5) nurses had been completed for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14 and 04/29/14. Ten (10) random care plans will be reviewed weekly for six weeks by RN/Unit Managers for appropriate interventions related to specific behavior care plan. This was verified 05/01/14 per interview with the Director of Nursing and review of the monitors already completed. The monitors will be completed on 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. This was verified on 05/01/14 by interview and review of in-service records as completed on

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F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) 03/20/14 by the RNs/Unit Managers/Nurse Supervisors and Department Heads.
F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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 observation of video recordings, interview, record review and review of the facility's Abuse/Neglect and Misappropriation of Property policy and procedure, it was determined the facility failed to ensure staff reported observed incidents of abuse/mistreatment and assess non-interviewable residents for symptoms of abuse/neglect for one (1) of five (5) sampled residents (Resident #1). Certified Nurse Aides (CNA) were video recorded by a Nanny Cam placed in Resident #1's and #2's shared room by a family member. The video recordings revealed inappropriate behaviors of CNAs #1, #2 and #3 (determined by schedule and assignment sheet), who were providing care for Resident #1. The video recordings revealed there were two (2) staff present at all times when care was being rendered to Resident #1 and none of the CNAs reported the recorded events to the Administrator. CNAs were video recorded on different dates, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner after care had been provided. The facility was made aware of the allegations of abuse and neglect on 03/19/14 when the Office of Attorney General and the Department for Community Based Services (DCBS) entered the facility to investigate the allegations; however, the facility failed to assess residents who were unable to speak for themselves for signs/symptoms of abuse/mistreatment. The facility's failure to ensure staff reported observed incidents of abuse/neglect/mistreatment and assess non-interviewable residents for signs/symptoms of abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist 01/15/14. The facility was notified of the Immediate Jeopardy on 04/22/14. The findings include: Review of the facility's policy and procedure, titled Policy Regarding Abuse/Neglect and Misappropriation of Resident Property, dated 09/24/09, revealed the policy and procedures shall be in place to prevent resident abuse and neglect. The policy revealed staff observing or hearing about such events will report the event immediately, either verbally or in writing, to their immediate supervisor and any partner having either direct or indirect knowledge of any event that might constitute abuse must report the event to the facility Administrator or their designee immediately. 1. Record review revealed the facility admitted Resident #1 on 08/13/09, with [DIAGNOSES REDACTED]. Interview with a family member of Resident #1, on 04/14/14 at 9:45 AM, revealed she had placed a Nanny Cam in the resident's room on 01/10/14 to monitor Resident #1's care after facial bruising was identified to the resident's face the first week of January. He/she stated staff was making faces at Resident #1, gesturing like they were going to stick a banana between the resident's legs; pointing their finger in the resident's face; and, holding Resident #1 down while laughing. Further interview revealed the Office of the Attorney General had viewed the video recordings on 03/19/14 and identified the CNAs as CNA #2 and CNA #3 by the schedule and assignment sheets. The SSA Surveyor's review of the video recordings provided by the family member, on 04/16/14, dating from 01/10/14 through 03/12/14 revealed inappropriate behaviors by CNAs #1, #2 and #3 (determined by schedule and assignment sheet), who were providing care for Resident #1. The video recordings revealed there were two (2) staff present at all times when care was being rendered to Resident #1. CNAs were video recorded on different days restraining Resident #1's hands during care, getting in the resident's face and pointing their finger at the resident in a threatening manner after care had been provided. One of the CNAs was observed bending over and biting or kissing the buttocks of the other CNA. Further observation of the video revealed one (1) of the CNAs picked a banana up off the resident's bed side table and made an inappropriate sexual gesture like she was going to stick the banana between the resident's legs; one CNA showed the other CNA her left breast and the other CNA performed a breast exam on herself in front of Resident #1; and, on another occasion Resident #1 repeatedly pushed the cover back from his/her face and one (1) of the CNAs flipped the cover back over the resident's face five (5) different times. The CNA pointed a finger near the resident's face and then made a taunting gesture as the CNA held her hands by her ears while waving her fingers. Interview with the Administrator and Director of Nursing (DON), on 04/14/14 at 3:15 PM, revealed no staff or residents had reported any abuse/neglect/mistreatment of [REDACTED]. Interview with the Director of Nursing (DON), on 04/16/14 at 3:45 PM, revealed their investigation after being made aware of the allegation of abuse/neglect/mistreatment did not include assessments of non-interviewable residents to determine if any residents had sign/symptoms of abuse/mistreatment. Attempts to contact CNA #1 and CNA #3 on 04/16/14 were unsuccessful due to their telephone numbers were disconnected. A telephone interview with CNA #2, on 04/21/14 at 12:15 PM, revealed CNA #2 revealed she had been suspended and questioned about rough handling of Resident #1. CNA #2 stated she had told the Administrator she did not do it (treat the resident roughly). **The facility implemented the following actions to remove the Immediate Jeopardy: On 03/19/14, the facility suspended and then terminated CNAs #1, #2, #3 and #4. CNA #1 was reported to the Nurse Aide Abuse Registry by the Administrator. On 04/21/14, the Regional Nurse provided oversight as Unit Managers assisted by other licensed staff (total of ten) and the RN Supervisor conducted physical assessments for signs/symptoms of possible abuse on all residents including Resident #1; no injuries were found. The care plans for Resident #1 were reviewed and updated with focus on interventions specific to the resident's behaviors. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. On 04/22/14, the Regional Nurse in-serviced the Administrator and Director of Nursing regarding the facility's abuse/neglect policy. Together they reviewed and revised the policy to include specific assessment of non-interviewable residents for potential abuse during investigations. The Medical Director was informed of the policy revision. Beginning 04/22/14, all facility employees were inserviced regarding the revision in the policy with employees on leave or were unavailable would have the inservice prior to working their next shift; this was completed on 04/23/14. Inservice training was provided to licensed staff by the DON, RNs and Unit Managers and Nurse Supervisors on recognizing and managing Alzheimer type dementia and emphasized the nurses' and CNAs' understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. This was initiated on 03/20/14 and completed on 03/21/14. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy including the types of abuse and interviewing residents. An additional four (4) weeks of monitoring was added following the 04/22/14 revision that included the assessment of non-interviewable residents for potential signs and symptoms of abuse. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Ten (10) random care plans will be reviewed weekly for six (6) weeks by the RN/Unit Managers for appropriate interventions related to specific behavior care plan. The monitors will be completed 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The State Survey Agency validated the Corrective action taken by the facility as follows: Record review for Resident #1 and Resident #2, on 05/01/14, revealed Resident #1 and Resident #2 were assessed by their physician on 03/20/14 and no new orders were given. On 05/01/14, record reviews for Residents #3, #4 and #5 revealed they had been assessed for injuries of unknown injuries and none were found. RN Unit Managers and Supervisors had assessed them. Interview with RN #6 on 05/01/14 at 11:45 AM revealed she and other Unit Managers had completed skin assessments on all residents in the facility on 04/23/14. Review of the inservice logs, on 05/01/14, revealed the Administrator and Director of Nursing were inserviced by the Regional Nurse related to the Policy Regarding Abuse/Neglect and Misappropriation of Resident Property. Interview with the Administrator and Director of Nursing on 05/01/14 at 10:00 AM verified the inservicing was completed. Review of the policy revision for the Abuse/Neglect and Misappropriation of Resident property, on 05/01/14, verified the revision regarding the assessment of non-interviewable patients for potential abuse during investigations. Review on 05/01/14 of the inservice logs, dated 04/22/14 and 04/23/14, revealed all staff was inserviced related to the revision of the policy on 04/23/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff from different shifts to include five (5) LPNs, an RN and eight (8) CNAs revealed the in-servicing had been provided by the DON, RNs/Unit Managers and Nurse Supervisors for Licensed Nurses and CNAs on Recognizing and Managing Alzheimer's Type Dementia and was completed on 03/21/14. Review on 05/01/14 of inservice logs dated 03/22/14 and 03/23/14, revealed all staff was provided in-service training by the DON, RNs/Unit Managers and Nurse Supervisors on Caregiver Stress and Burnout and was completed on 03/22/14. Interviews conducted on

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) 05/01/14 (between 11:15 AM and 4:00 PM) with staff which included five (5) LPNs, an RN and eight (8) CNAs from all shifts, revealed the inservicing had been provided. On 05/01/14 at 11:35 AM, CNA #10 verified through interview that she had received the inservice training by the DON and Unit Manager. The inservice training included the revision of the abuse/neglect policy which included the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:40 AM, LPN #2 verified through interview that she had received the inservice training by the DON. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview at 11:45 on 05/01/14 with RN #2 revealed she had received inservice training by the DON and she had also provided some of the training to the CNAs. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:05 PM and interview with LPN #3 revealed the DON had provided inservice training on the abuse/neglect policy changes, the types of abuse, stress and staff burnout and managing behaviors of residents with Alzheimer's type behaviors. Care plans for residents with behaviors were also included in the training. An interview on 05/01/14 at 12:05 PM with CNA #11 revealed she had been provided inservice training by the Unit Manager. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. Interview with CNAs #12 and #13 on 05/01/14 at 12:10 PM revealed they had received lots of inservicing by the DON and Unit Managers that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:27 PM CNA #14 revealed in interview that she had received inservice training by the Administrative Nurses related to burnout, behaviors of residents, the changes in the abuse policy including residents that were not interviewable. Interview with CNA #15 on 05/01/14 at 12:45 PM revealed she had been provided inservice training by a nurse and the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:48 PM, an interview with LPN #5 revealed she had been provided numerous inservice trainings recently that included the policy, resident behaviors and appropriate interventions, staff burnout and what to do. Review of inservice records revealed inservice training had been provided to the DON, RNs, Unit Managers and Clinical Social Workers by the Regional Nurse and Regional Director of Social Service related to Care Planning that covered ensuring interventions related to resident behaviors were care planned as needed. Interviews on 05/01/14 (between 11:15 AM and 4:00 PM) with the DON, RN, Unit Managers and three (3) Licensed Social Workers revealed they had been provided the inservicing which was completed on 04/23/14. Interview on 05/01/14 at 11:15 AM with the Social Service Director revealed she had received inservice training from the Regional Nurse and Regional Director of Social Service related to resident behavior care plans on 04/24/14. The Social Service Director stated she had also received the inservice training that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:45 AM, an interview with RN #2 revealed she had received inservice training by the Regional Director of Social Service related to resident care plans for behaviors of residents and she had received training by the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview with LPN #2 on 05/01/14 at 11:40 AM revealed she had received inservice training by the Regional Nurse and Regional Director of Social Service on 04/24/14. The training was related to resident care plans for residents with behaviors. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy and additional four (4) weeks following the 04/22/14 revision. This will be completed by 05/30/14. On 05/01/14, Quality Assurance Monitors dated for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14, 04/22/14 and 04/29/14 were reviewed by the Survey Agency and verified as being completed. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Review of documented interviews for the weeks of 03/23/14, 04/01/14, 04/15/14, 04/22/14 and 04/29/14 were verified completed. Review of the Quality Assurance Monitors were reviewed by the State Survey Agency on 05/01/14 and included the interviews of fifteen (15) CNAs and five (5) nurses had been completed for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14 and 04/29/14. Ten (10) random care plans will be reviewed weekly for six weeks by RN/Unit Managers for appropriate interventions related to specific behavior care plan. This was verified 05/01/14 per interview with the Director of Nursing and review of the monitors already completed. The monitors will be completed on 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. This was verified on 05/01/14 by interview and review of in-service records as completed on 03/20/14 by the RNs/Unit Managers/Nurse Supervisors and Department Heads.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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 review of video recordings and the facility's Abuse/Neglect and Misappropriation of Property policy and procedure, it was determined the facility failed to implement the facility's Abuse/Neglect policy and procedure for one (1) of five (5) sampled residents (Resident #1). Certified Nurse Aides were video recorded by a Nanny Cam placed in Resident #1's and #2's shared room by a family member. The video recordings revealed inappropriate behaviors of CNAs #1, #2 and #3 (determined by schedule and assignment sheet), who were providing care for Resident #1. The video recordings revealed there were two (2) staff present at all times when care was being rendered to Resident #1 and none of the CNAs reported the recorded events to the Administrator. CNAs were video recorded on different dates, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner after care had been provided. The facility was made aware of the allegations of abuse and neglect on 03/19/14 when the Office of the Attorney General and the Department for Community Based Services (DCBS) entered the facility to investigate the allegations. However, the facility failed to assess residents who were unable to speak for themselves for signs/symptoms of abuse. In addition, the facility failed to identify that Resident #1 had behaviors that might lead to conflict with staff or other residents and failed to develop a care plan with interventions to address the resident's aggressive behaviors with care that placed the resident at an increased risk for abuse. The facility's failure to implement the procedures in their abuse/neglect policy to protect residents from abuse and misappropriation of property has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist on 01/15/14. The facility was notified of the Immediate Jeopardy on 04/22/14. The findings include: Review of the facility's policy and procedure, titled Policy Regarding Abuse/Neglect and Misappropriation of Resident Property, dated 09/24/09, revealed the policy and procedures shall be in place to prevent resident abuse, neglect and misappropriation of resident property. Further review revealed staff observing or hearing about such events will report the event immediately, either verbally or in writing, to their immediate supervisor and any partner having either direct or indirect knowledge of any event that might constitute abuse must report the event to the facility Administrator or their designee immediately. The policy also stated residents with needs and behaviors that might lead to conflict with staff or other residents will be identified by the Care Planning Team and will follow through with interventions designed to minimize the risk of conflict or neglect, such as: Residents with a history of aggressive behaviors, residents with communication disorders, and residents who require heavy nursing care, or are totally dependent

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	185093	A. BUILDING _____ B. WING _____	**05/02/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, GLASGOW	**109 HOMEWOOD BLVD. GLASGOW, KY 42141**

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) on nursing care, will be considered as potential victims of abuse. The interventions designed to meet the needs of such residents will include, but will not be limited to identification of residents whose personal histories render them at risk for abusing other residents or staff, assessments of appropriate intervention strategies to prevent occurrences, monitoring the resident for any changes that would trigger abusive behavior and reassessment of the protective strategies on a regular basis. 1. Record review revealed the facility admitted Resident #1 on 08/13/09 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/20/14, revealed the staff assessed Resident #1's cognition as severely impaired; and, the resident had behaviors of being resistive to care at times with behaviors of kicking, screaming, hitting and smacking at staff during direct care. Review of the Care Plan for Activities of Daily Living, dated 04/02/14, revealed an intervention to Allow me time to calm down if (I) become agitated/aggressive. Further review revealed there was no care plan or interventions to address the resident's combative and resistive behaviors to care at times which could place the resident at an increased risk for abuse. Review of the video recordings provided by Resident #1 and Resident #2's family member on 04/16/14 revealed Certified Nursing Aides (CNA) were recorded on different dates (01/10/14 through 03/12/14, on eight different events) with at least two (2) CNAs in the room, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner just inches from his/her face after care had been provided. Interview with the Administrator and Director of Nursing (DON), on 04/14/14 at 3:15 PM, revealed there had not been any allegations of mistreatment of [REDACTED]. The Administrator stated he was told by the DCBS representative to suspend three (3) people that included CNA #1, CNA #2 and CNA #3. The Administrator revealed on 04/08/14, the OAG investigator revealed eight (8) to ten (10) video clips to him. The Administrator stated the OAG investigator stated the CNAs behavior was unprofessional and poor technique but did not rise to criminal. The facility suspended those staff and initiated an investigation. Interview with the Director of Nursing (DON), on 04/16/14 at 3:45 PM, revealed when the facility was made aware of the allegations on 03/19/14, the facility did not perform assessments of residents that were not interviewable to assess for any signs or symptoms of possible abuse during their investigation. Interview with the Administrator and DON, on 04/17/14 at 10:15 AM, revealed they ensured compliance with policies by relying on the residents, nurses and staff to report allegations of abuse/neglect. They stated Administrative staff conducted room checks three days a week and abuse and neglect were discussed in care plan meetings and family meetings. They revealed the Unit Managers were also scheduled for surprise visits one (1) time a week which would be a way of ensuring compliance. **The facility implemented the following actions to remove the Immediate Jeopardy: On 03/19/14, the facility suspended and then terminated CNAs #1, #2, #3 and #4. CNA #1 was reported to the Nurse Aide Abuse Registry by the Administrator. On 04/21/14, the Regional Nurse provided oversight as Unit Managers assisted by other licensed staff (total of ten) and the RN Supervisor conducted physical assessments for signs/symptoms of possible abuse on all residents including Resident #1; no injuries were found. The care plans for Resident #1 were reviewed and updated with focus on interventions specific to the resident's behaviors. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. On 04/22/14, the Regional Nurse in-serviced the Administrator and Director of Nursing regarding the facility's abuse/neglect policy. Together they reviewed and revised the policy to include specific assessment of non-interviewable residents for potential abuse during investigations. The Medical Director was informed of the policy revision. Beginning 04/22/14, all facility employees were inserviced regarding the revision in the policy with employees on leave or were unavailable would have the inservice prior to working their next shift; this was completed on 04/23/14. Inservice training was provided to licensed staff by the DON, RNs and Unit Managers and Nurse Supervisors on recognizing and managing Alzheimer type dementia and emphasized the nurses' and CNAs' understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. This was initiated on 03/20/14 and completed on 03/21/14. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy including the types of abuse and interviewing residents. An additional four (4) weeks of monitoring was added following the 04/22/14 revision that included the assessment of non-interviewable residents for potential signs and symptoms of abuse. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Ten (10) random care plans will be reviewed weekly for six (6) weeks by the RN/Unit Managers for appropriate interventions related to specific behavior care plan. The monitors will be completed 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The State Survey Agency validated the Corrective action taken by the facility as follows: Record review for Resident #1 and Resident #2, on 05/01/14, revealed Resident #1 and Resident #2 were assessed by their physician on 03/20/14 and no new orders were given. On 05/01/14, record reviews for Residents #3, #4 and #5 revealed they had been assessed for injuries of unknown injuries and none were found. RN Unit Managers and Supervisors had assessed them. Interview with RN #6 on 05/01/14 at 11:45 AM revealed she and other Unit Managers had completed skin assessments on all residents in the facility on 04/23/14. Review of the inservice logs, on 05/01/14, revealed the Administrator and Director of Nursing were inserviced by the Regional Nurse related to the Policy Regarding Abuse/Neglect and Misappropriation of Resident Property. Interview with the Administrator and Director of Nursing on 05/01/14 at 10:00 AM verified the inservicing was completed. Review of the policy revision for the Abuse/Neglect and Misappropriation of Resident property, on 05/01/14, verified the revision regarding the assessment of non-interviewable patients for potential abuse during investigations. Review on 05/01/14 of the inservice logs, dated 04/22/14 and 04/23/14, revealed all staff was inserviced related to the revision of the policy on 04/23/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff from different shifts to include five (5) LPNs, an RN and eight (8) CNAs revealed the in-servicing had been provided by the DON, RNs/Unit Managers and Nurse Supervisors for Licensed Nurses and CNAs on Recognizing and Managing Alzheimer's Type Dementia and was completed on 03/21/14. Review on 05/01/14 of inservice logs dated 03/22/14 and 03/23/14, revealed all staff was provided in-service training by the DON, RNs/Unit Managers and Nurse Supervisors on Caregiver Stress and Burnout and was completed on 03/22/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff which included five (5) LPNs, an RN and eight (8) CNAs from all shifts, revealed the inservicing had been provided. On 05/01/14 at 11:35 AM, CNA #10 verified through interview that she had received the inservice training by the DON and Unit Manager. The inservice training included the revision of the abuse/neglect policy which included the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:40 AM, LPN #2 verified through interview that she had received the inservice training by the DON. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview at 11:45 on 05/01/14 with RN #2 revealed she had received inservice training by the DON and she had also provided some of the training to the CNAs. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:05 PM and interview with LPN #3 revealed the DON had provided inservice training on the abuse/neglect policy changes, the types of abuse, stress and staff burnout and managing behaviors of residents with Alzheimer's type behaviors. Care plans for residents with behaviors were also included in the training. An interview on 05/01/14 at 12:05 PM with CNA #11 revealed she had been provided inservice training by the Unit Manager. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. Interview with CNAs #12 and #13 on 05/01/14 at 12:10 PM revealed they had received lots of inservicing by the DON and Unit Managers that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:27 PM CNA #14 revealed in interview that she had received inservice training by the Administrative Nurses related to burnout, behaviors of residents, the changes in the abuse policy including residents that were not interviewable. Interview with CNA #15 on 05/01/14 at 12:45 PM revealed she had been provided inservice training by a nurse and the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5) included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:48 PM, an interview with LPN #5 revealed she had been provided numerous inservice trainings recently that included the policy, resident behaviors and appropriate interventions, staff burnout and what to do. Review of inservice records revealed inservice training had been provided to the DON, RNs, Unit Managers and Clinical Social Workers by the Regional Nurse and Regional Director of Social Service related to Care Planning that covered ensuring interventions related to resident behaviors were care planned as needed. Interviews on 05/01/14 (between 11:15 AM and 4:00 PM) with the DON, RN, Unit Managers and three (3) Licensed Social Workers revealed they had been provided the inservicing which was completed on 04/23/14. Interview on 05/01/14 at 11:15 AM with the Social Service Director revealed she had received inservice training from the Regional Nurse and Regional Director of Social Service related to resident behavior care plans on 04/24/14. The Social Service Director stated she had also received the inservice training that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:45 AM, an interview with RN #2 revealed she had received inservice training by the Regional Director of Social Service related to resident care plans for behaviors of residents and she had received training by the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview with LPN #2 on 05/01/14 at 11:40 AM revealed she had received inservice training by the Regional Nurse and Regional Director of Social Service on 04/24/14. The training was related to resident care plans for residents with behaviors. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy and additional four (4) weeks following the 04/22/14 revision. This will be completed by 05/30/14. On 05/01/14, Quality Assurance Monitors dated for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14, 04/22/14 and 04/29/14 were reviewed by the Survey Agency and verified as being completed. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Review of documented interviews for the weeks of 03/23/14, 04/01/14, 04/15/14, 04/22/14 and 04/29/14 were verified completed. Review of the Quality Assurance Monitors were reviewed by the State Survey Agency on 05/01/14 and included the interviews of fifteen (15) CNAs and five (5) nurses had been completed for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14 and 04/29/14. Ten (10) random care plans will be reviewed weekly for six weeks by RN/Unit Managers for appropriate interventions related to specific behavior care plan. This was verified 05/01/14 per interview with the Director of Nursing and review of the monitors already completed. The monitors will be completed on 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. This was verified on 05/01/14 by interview and review of in-service records as completed on 03/20/14 by the RNs/Unit Managers/Nurse Supervisors and Department Heads.
F 0280 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility's Policy Regarding Abuse/Neglect and Misappropriation of Resident Property and Care Plan Development policy, it was determined the facility failed to revise the care plan for one (1) of five (5) sampled residents (Resident #1). Resident #1 had behaviors of being resistive and combative toward staff during care but the facility failed to revise the care plan to include interventions to try to decrease the risk for abuse due to these behaviors. Resident #1 was assessed and identified to have behaviors of resisting care and being combative with staff during care which placed the resident at an increased risk for abuse. The facility failed to revise the care plan to include interventions to address these behavior to try to decrease the risk for abuse. Review of the video recordings, on 04/16/14, provided by the family revealed two (2) CNAs providing care to Resident #1 on eight (8) occasions from 01/10/14 through 03/12/14 while the resident was showing behaviors of resistance to care. The CNAs were observed restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing their finger at the resident in a threatening manner. The facility's failure to revise the care plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist on 01/15/14. The facility was notified of the Immediate Jeopardy on 04/22/14. The findings include: Review of the facility's policy, titled, Care Plan Development, last revised 07/03/08, revealed the staff responsible for the development of the care plan was the Nursing staff as close to the patient's care as possible and the problems were patient conditions, needs, or weaknesses which currently do or potentially could prevent the patient from achieving or maintaining the highest practicable level of well being. The policy also revealed the Problems should be stated using simple language that any center partner can understand. Review of the facility's policy and procedure, titled Policy Regarding Abuse/Neglect and Misappropriation of Resident Property, dated 09/24/09, revealed the policy and procedures shall be in place to prevent resident abuse, neglect and misappropriation of resident property. The policy also stated residents with needs and behaviors that might lead to conflict with staff or other residents will be identified by the Care Planning Team and will follow through with interventions designed to minimize the risk of conflict. Record review revealed the facility admitted Resident #1 on 08/13/09, with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/20/14, revealed the facility assessed Resident #1's cognition as severely impaired (unable to complete Brief Interview for Mental Status interview) and had behaviors of being resistive to care at times with behaviors of kicking, screaming, hitting and smacking at staff during direct care. Review of Resident #1's Comprehensive Care Plan for Activities of Daily Living (ADLs), dated 04/02/14, revealed an intervention to Allow me time to calm down if (I) become agitated/aggressive. Further review of the Comprehensive Care Plan revealed there was no care plan or other interventions to address the resident's combative and resistive behaviors to care at times which could place the resident at an increased risk for abuse. Interview with a family member of Resident #1, on 04/14/14 at 9:45 AM, revealed she had placed a Nanny Cam in the room on 01/10/14 to monitor Resident #1's care after facial bruising was identified to Resident #1's face the first week of January. Review of the video recordings, on 04/16/14, provided by the family revealed two (2) CNAs providing care to Resident #1 from 01/10/14 through 03/12/14. There were eight (8) different events on different dates that revealed Resident #1 being resistive and/or combative with care. The CNAs were recorded restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing their finger at the resident in a threatening manner. Interview, on 04/15/14 at 3:00 PM with CNA #9, revealed when any resident becomes resistant or combative toward caregivers, staff should get somebody else and try again. Interviews, on 04/15/14 at 10:30 PM with CNA #5 and CNA #9, revealed when a resident becomes combative during care they stop, try again and report to the nurse. Interview with Registered Nurse #1, on 04/21/14 at 1:20 PM, revealed she would expect staff to walk away when a resident was displaying resistive and combative behaviors and to report those behaviors to the nurse. Interview with the Social Service Worker (SSW), on 05/16/14 at 5:30 PM (post survey interview), revealed she did not think residents with behaviors were at a higher risk for abuse. She stated the facility would develop a care plan around what triggers the resident's behavior and would try to find the root cause of the behavior. The Social Worker stated to her knowledge Resident #1 never had any overt behaviors. Interview with the MDS Coordinator, on 05/16/14 at 3:30 PM (post survey interview), revealed the residents' care plans were developed from the information they received from the chart, resident and family as well as the staff. She stated the care plan was reviewed by everyone on the Interdisciplinary Team (MDS Coordinator, Dietary, SSW, Activities and Nursing). She stated there was no care plan in place to address Resident #1's combative or resistive behavior; however, she said there was a care plan, dated 04/02/14, with an intervention to allow the resident to calm down if became agitated or aggressive. Interview with the Director of Nursing (DON), on 04/17/14 at 9:00 AM, revealed she felt interventions to manage Resident #1's resistive and combative behaviors could be pulled from all the different care plans that were in place for the resident in the Complete Care Plan. The DON stated a Behavior care plan was not developed until 04/11/14 and prior to that date the intervention to allow time to calm was the only intervention in place. **The facility implemented the following actions to remove the Immediate Jeopardy: On 03/19/14, the facility suspended and then terminated CNAs #1, #2, #3

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) and #4. CNA #1 was reported to the Nurse Aide Abuse Registry by the Administrator. On 04/21/14, the Regional Nurse provided oversight as Unit Managers assisted by other licensed staff (total of ten) and the RN Supervisor conducted physical assessments for signs/symptoms of possible abuse on all residents including Resident #1; no injuries were found. The care plans for Resident #1 were reviewed and updated with focus on interventions specific to the resident's behaviors. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. On 04/22/14, the Regional Nurse in-serviced the Administrator and Director of Nursing regarding the facility's abuse/neglect policy. Together they reviewed and revised the policy to include specific assessment of non-interviewable residents for potential abuse during investigations. The Medical Director was informed of the policy revision. Beginning 04/22/14, all facility employees were inserviced regarding the revision in the policy with employees on leave or were unavailable would have the inservice prior to working their next shift; this was completed on 04/23/14. Inservice training was provided to licensed staff by the DON, RNs and Unit Managers and Nurse Supervisors on recognizing and managing Alzheimer type dementia and emphasized the nurses' and CNAs' understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. This was initiated on 03/20/14 and completed on 03/21/14. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy including the types of abuse and interviewing residents. An additional four (4) weeks of monitoring was added following the 04/22/14 revision that included the assessment of non-interviewable residents for potential signs and symptoms of abuse. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Ten (10) random care plans will be reviewed weekly for six (6) weeks by the RN/Unit Managers for appropriate interventions related to specific behavior care plan. The monitors will be completed 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The State Survey Agency validated the Corrective action taken by the facility as follows: Record review for Resident #1 and Resident #2, on 05/01/14, revealed Resident #1 and Resident #2 were assessed by their physician on 03/20/14 and no new orders were given. On 05/01/14, record reviews for Residents #3, #4 and #5 revealed they had been assessed for injuries of unknown injuries and none were found. RN Unit Managers and Supervisors had assessed them. Interview with RN #6 on 05/01/14 at 11:45 AM revealed she and other Unit Managers had completed skin assessments on all residents in the facility on 04/23/14. Review of the inservice logs, on 05/01/14, revealed the Administrator and Director of Nursing were inserviced by the Regional Nurse related to the Policy Regarding Abuse/Neglect and Misappropriation of Resident Property. Interview with the Administrator and Director of Nursing on 05/01/14 at 10:00 AM verified the inservicing was completed. Review of the policy revision for the Abuse/Neglect and Misappropriation of Resident property, on 05/01/14, verified the revision regarding the assessment of non-interviewable patients for potential abuse during investigations. Review on 05/01/14 of the inservice logs, dated 04/22/14 and 04/23/14, revealed all staff was inserviced related to the revision of the policy on 04/23/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff from different shifts to include five (5) LPNs, an RN and eight (8) CNAs revealed the in-servicing had been provided by the DON, RNs/Unit Managers and Nurse Supervisors for Licensed Nurses and CNAs on Recognizing and Managing Alzheimer's Type Dementia and was completed on 03/21/14. Review on 05/01/14 of inservice logs dated 03/22/14 and 03/23/14, revealed all staff was provided in-service training by the DON, RNs/Unit Managers and Nurse Supervisors on Caregiver Stress and Burnout and was completed on 03/22/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff which included five (5) LPNs, an RN and eight (8) CNAs from all shifts, revealed the inservicing had been provided. On 05/01/14 at 11:35 AM, CNA #10 verified through interview that she had received the inservice training by the DON and Unit Manager. The inservice training included the revision of the abuse/neglect policy which included the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:40 AM, LPN #2 verified through interview that she had received the inservice training by the DON. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview at 11:45 on 05/01/14 with RN #2 revealed she had received inservice training by the DON and she had also provided some of the training to the CNAs. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:05 PM and interview with LPN #3 revealed the DON had provided inservice training on the abuse/neglect policy changes, the types of abuse, stress and staff burnout and managing behaviors of residents with Alzheimer's type behaviors. Care plans for residents with behaviors were also included in the training. An interview on 05/01/14 at 12:05 PM with CNA #11 revealed she had been provided inservice training by the Unit Manager. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. Interview with CNAs #12 and #13 on 05/01/14 at 12:10 PM revealed they had received lots of inservicing by the DON and Unit Managers that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:27 PM CNA #14 revealed in interview that she had received inservice training by the Administrative Nurses related to burnout, behaviors of residents, the changes in the abuse policy including residents that were not interviewable. Interview with CNA #15 on 05/01/14 at 12:45 PM revealed she had been provided inservice training by a nurse and the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:48 PM, an interview with LPN #5 revealed she had been provided numerous inservice trainings recently that included the policy, resident behaviors and appropriate interventions, staff burnout and what to do. Review of inservice records revealed inservice training had been provided to the DON, RNs, Unit Managers and Clinical Social Workers by the Regional Nurse and Regional Director of Social Service related to Care Planning that covered ensuring interventions related to resident behaviors were care planned as needed. Interviews on 05/01/14 (between 11:15 AM and 4:00 PM) with the DON, RN, Unit Managers and three (3) Licensed Social Workers revealed they had been provided the inservicing which was completed on 04/23/14. Interview on 05/01/14 at 11:15 AM with the Social Service Director revealed she had received inservice training from the Regional Nurse and Regional Director of Social Service related to resident behavior care plans on 04/24/14. The Social Service Director stated she had also received the inservice training that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:45 AM, an interview with RN #2 revealed she had received inservice training by the Regional Director of Social Service related to resident care plans for behaviors of residents and she had received training by the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview with LPN #2 on 05/01/14 at 11:40 AM revealed she had received inservice training by the Regional Nurse and Regional Director of Social Service on 04/24/14. The training was related to resident care plans for residents with behaviors. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy and additional four (4) weeks following the 04/22/14 revision. This will be completed by 05/30/14. On 05/01/14, Quality Assurance Monitors dated for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14, 04/22/14 and 04/29/14 were reviewed by the Survey Agency and verified as being completed. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Review of documented interviews for the weeks of 03/23/14, 04/01/14, 04/15/14, 04/22/14 and 04/29/14 were verified completed. Review of the Quality Assurance Monitors were reviewed by the State Survey Agency on 05/01/14 and included the interviews of fifteen (15) CNAs and five (5) nurses had been completed for the weeks of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185093	A. BUILDING _____ B. WING _____	05/02/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, GLASGOW	109 HOMEWOOD BLVD. GLASGOW, KY 42141

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 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) 03/23/14, 04/01/14, 04/08/14, 04/15/14 and 04/29/14. Ten (10) random care plans will be reviewed weekly for six weeks by RN/Unit Managers for appropriate interventions related to specific behavior care plan. This was verified 05/01/14 per interview with the Director of Nursing and review of the monitors already completed. The monitors will be completed on 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. This was verified on 05/01/14 by interview and review of in-service records as completed on 03/20/14 by the RNs/Unit Managers/Nurse Supervisors and Department Heads.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the Administrator's job description, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for one (1) of five (5) sampled residents (Resident #1). The facility failed to have an effective system in place to ensure residents were safe and free from abusive treatment. The facility failed to ensure staff reported observed mistreatment of [REDACTED]. Facility Certified Nurse Aides (CNAs) were video recorded by a Nanny Cam placed in Resident #1's and Resident #2's room by a family member. The video recordings revealed inappropriate behaviors of CNAs, who were providing care for Resident #1. CNAs were recorded on different dates, restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner. Additionally, Resident #1 was not identified as a potential victim of abuse, as per the facility's policy and no interventions specific to meet his/her needs were in place in the plan of care. The facility's failure to be administered in a manner that enabled it to use its resources effectively and efficiently has caused or is likely to cause serious injury, harm or impairment, or death to a resident. Immediate Jeopardy was identified on 04/22/14 and determined to exist on 01/15/14. The facility was notified of the Immediate Jeopardy on 04/22/14. The findings include: Review of the facility's Job Description for the Administrator, last revised 06/01/09, revealed The Administrator has complete administrative and managerial responsibilities within the health care center, acting as liaison, motivator, coordinator and support person for Department Directors, other partners, patients, families, visitors, physicians and the local community. The job description included: Must be able to make administrative decisions, Ability to interpret and implement regulations (State and Federal) and Assures compliance with State and Federal Regulations and Center policies. Review of the video recordings provided by Resident #1 and Resident #2's family member on 04/16/14 revealed Certified Nursing Aides (CNA) were recorded on 01/10/14 through 03/12/14, on eight (8) occasions with at least two (2) CNAs in the room, displaying some of the following behaviors: restraining Resident #1's hands during care, making inappropriate gestures, getting in the resident's face and pointing a finger at the resident in a threatening manner just inches from his/her face and not providing incontinent care several hours (six hours and forty minutes). Interviews with the Administrator and Director of Nursing (DON) on 04/14/14 at 3:15 PM; and, on 04/17/14 at 10:15 AM revealed the facility was made aware of the allegation on 03/19/14 by the Office of Attorney General's (OAG) Investigator and a Department of Community Based Services (DCBS)Representative. The Administrator was told by the DCBS representative to suspend three (3) people that included CNA #1, CNA #4 and CNA #3. On 04/08/14, the OAG Investigator revealed eight (8) to ten (10) video clips to the Administrator. The Administrator stated the OAG Investigator stated the CNAs behavior was unprofessional and there was poor technique but it did not rise to criminal. The OAG Investigator informed the Administrator that CNA #1 had admitted to stealing money from Resident #2 and would be charged with a criminal offense. Further interview with the DON, on 04/16/14 at 3:45 PM, revealed no assessments had been completed by the facility to identify any signs and symptoms of possible abuse of residents who could not speak for themselves. Interview with the Administrator, on 04/17/14 at 10:15 AM, revealed he would have expected staff to report any observed abuse or neglect and that he relied on the residents, nurses and staff to report any alleged abuse or neglect. Three (3) days a week room checks with administrative staff were done weekly and Unit Managers were scheduled for surprise visits one time a week. However, no assessments of non-interviewable residents had been completed as the facility relied on staff to report. **The facility implemented the following actions to remove the Immediate Jeopardy: On 03/19/14, the facility suspended and then terminated CNAs #1, #2, #3 and #4. CNA #1 was reported to the Nurse Aide Abuse Registry by the Administrator. On 04/21/14, the Regional Nurse provided oversight as Unit Managers assisted by other licensed staff (total of ten) and the RN Supervisor conducted physical assessments for signs/symptoms of possible abuse on all residents including Resident #1; no injuries were found. The care plans for Resident #1 were reviewed and updated with focus on interventions specific to the resident's behaviors. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. On 04/22/14, the Regional Nurse in-serviced the Administrator and Director of Nursing regarding the facility's abuse/neglect policy. Together they reviewed and revised the policy to include specific assessment of non-interviewable residents for potential abuse during investigations. The Medical Director was informed of the policy revision. Beginning 04/22/14, all facility employees were inserviced regarding the revision in the policy with employees on leave or were unavailable would have the inservice prior to working their next shift; this was completed on 04/23/14. Inservice training was provided to licensed staff by the DON, RNs and Unit Managers and Nurse Supervisors on recognizing and managing Alzheimer type dementia and emphasized the nurses' and CNAs' understanding of person centered interventions when caring for residents with dementia, specifically combative behaviors. This was initiated on 03/20/14 and completed on 03/21/14. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy including the types of abuse and interviewing residents. An additional four (4) weeks of monitoring was added following the 04/22/14 revision that included the assessment of non-interviewable residents for potential signs and symptoms of abuse. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Ten (10) random care plans will be reviewed weekly for six (6) weeks by the RN/Unit Managers for appropriate interventions related to specific behavior care plan. The monitors will be completed 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The State Survey Agency validated the Corrective action taken by the facility as follows: Record review for Resident #1 and Resident #2, on 05/01/14, revealed Resident #1 and Resident #2 were assessed by their physician on 03/20/14 and no new orders were given. On 05/01/14, record reviews for Residents #3, #4 and #5 revealed they had been assessed for injuries of unknown injuries and none were found. RN Unit Managers and Supervisors had assessed them. Interview with RN #6 on 05/01/14 at 11:45 AM revealed she and other Unit Managers had completed skin assessments on all residents in the facility on 04/23/14. Review of the inservice logs, on 05/01/14, revealed the Administrator and Director of Nursing were inserviced by the Regional Nurse related to the Policy Regarding Abuse/Neglect and Misappropriation of Resident Property. Interview with the Administrator and Director of Nursing on 05/01/14 at 10:00 AM verified the inservicing was completed. Review of the policy revision for the Abuse/Neglect and Misappropriation of Resident property, on 05/01/14, verified the revision regarding the assessment of non-interviewable patients for potential abuse during investigations. Review on 05/01/14 of the inservice logs, dated 04/22/14 and 04/23/14, revealed all staff was inserviced related to the revision of the policy on 04/23/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff from different shifts to include five (5) LPNs, an RN and eight (8) CNAs revealed the in-servicing had been provided by the DON, RNs/Unit Managers and Nurse Supervisors for Licensed Nurses and CNAs on Recognizing and Managing Alzheimer's Type Dementia and was completed on 03/21/14. Review on 05/01/14 of inservice logs dated 03/22/14 and 03/23/14, revealed all staff was provided in-service training by the DON, RNs/Unit Managers and Nurse Supervisors on Caregiver Stress and Burnout and was completed on 03/22/14. Interviews conducted on 05/01/14 (between 11:15 AM and 4:00 PM) with staff which included five (5) LPNs, an RN and eight (8) CNAs from all shifts, revealed the inservicing had been provided. On 05/01/14 at 11:35 AM, CNA #10 verified through interview that she had received the inservice training by the DON and Unit Manager. The inservice training included the revision of the abuse/neglect policy which included the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:40 AM, LPN #2 verified through interview that she had received the inservice training by the DON. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also

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	185093	A. BUILDING _____ B. WING _____	**05/02/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, GLASGOW	**109 HOMEWOOD BLVD. GLASGOW, KY 42141**

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview at 11:45 on 05/01/14 with RN #2 revealed she had received inservice training by the DON and she had also provided some of the training to the CNAs. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:05 PM and interview with LPN #3 revealed the DON had provided inservice training on the abuse/neglect policy changes, the types of abuse, stress and staff burnout and managing behaviors of residents with Alzheimer's type behaviors. Care plans for residents with behaviors were also included in the training. An interview on 05/01/14 at 12:05 PM with CNA #11 revealed she had been provided inservice training by the Unit Manager. The inservice training included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. Interview with CNAs #12 and #13 on 05/01/14 at 12:10 PM revealed they had received lots of inservicing by the DON and Unit Managers that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:27 PM CNA #14 revealed in interview that she had received inservice training by the Administrative Nurses related to burnout, behaviors of residents, the changes in the abuse policy including residents that were not interviewable. Interview with CNA #15 on 05/01/14 at 12:45 PM revealed she had been provided inservice training by a nurse and the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 12:48 PM, an interview with LPN #5 revealed she had been provided numerous inservice trainings recently that included the policy, resident behaviors and appropriate interventions, staff burnout and what to do. Review of inservice records revealed inservice training had been provided to the DON, RNs, Unit Managers and Clinical Social Workers by the Regional Nurse and Regional Director of Social Service related to Care Planning that covered ensuring interventions related to resident behaviors were care planned as needed. Interviews on 05/01/14 (between 11:15 AM and 4:00 PM) with the DON, RN, Unit Managers and three (3) Licensed Social Workers revealed they had been provided the inservicing which was completed on 04/23/14. Interview on 05/01/14 at 11:15 AM with the Social Service Director revealed she had received inservice training from the Regional Nurse and Regional Director of Social Service related to resident behavior care plans on 04/24/14. The Social Service Director stated she had also received the inservice training that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. On 05/01/14 at 11:45 AM, an interview with RN #2 revealed she had received inservice training by the Regional Director of Social Service related to resident care plans for behaviors of residents and she had received training by the DON that included the revision of the abuse/neglect policy to include the types of abuse/neglect, assessment of non-interviewable residents for signs and symptoms of potential abuse. The training also included training on caregiver stress and burnout, recognizing and managing Alzheimer's type behaviors. An interview with LPN #2 on 05/01/14 at 11:40 AM revealed she had received inservice training by the Regional Nurse and Regional Director of Social Service on 04/24/14. The training was related to resident care plans for residents with behaviors. Quality Assurance Monitors began the week of 03/23/14 and included twenty (20) random employees to be interviewed per week for six (6) weeks to determine their understanding of the abuse policy and additional four (4) weeks following the 04/22/14 revision. This will be completed by 05/30/14. On 05/01/14, Quality Assurance Monitors dated for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14, 04/22/14 and 04/29/14 were reviewed by the Survey Agency and verified as being completed. Fifteen (15) random CNAs and five (5) random nurses to be interviewed for understanding of care and interacting with residents with dementia. Fifteen (15) random CNAs and five (5) nurses per week to be interviewed for understanding of care giver burnout. Review of documented interviews for the weeks of 03/23/14, 04/01/14, 04/15/14, 04/22/14 and 04/29/14 were verified completed. Review of the Quality Assurance Monitors were reviewed by the State Survey Agency on 05/01/14 and included the interviews of fifteen (15) CNAs and five (5) nurses had been completed for the weeks of 03/23/14, 04/01/14, 04/08/14, 04/15/14 and 04/29/14. Ten (10) random care plans will be reviewed weekly for six weeks by RN/Unit Managers for appropriate interventions related to specific behavior care plan. This was verified 05/01/14 per interview with the Director of Nursing and review of the monitors already completed. The monitors will be completed on 05/30/14 and overseen by the Regional Nurse. All Quality Assurance monitors to be reviewed by the Regional Nurse with the Director of Nursing and will be reported to the Quality Assurance Committee. The facility began interviewing employees on 03/19/14 as part of their in-service training on the facility's abuse policy. This was verified on 05/01/14 by interview and review of in-service records as completed on 03/20/14 by the RNs/Unit Managers/Nurse Supervisors and Department Heads.