STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185195	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKVIEW NURSING & REHABILITATION CENTER	10456 US HWY 62 CALVERT CITY, KY 42029

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 0221 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of witness statements and the facility's policy and procedure, it was determined the facility failed to ensure residents were free of physical restraints used for the purpose of discipline or staff's convenience for one (1) of fifteen (15) sampled residents (Resident #4). On 11/19/14, Certified Nursing Assistant (CNA) #2 restrained Resident #4 by wrapping a sheet/blanket across the resident's waist and securing it to the back of the wheelchair because the resident was trying to release the belt and the alarm kept sounding. This was observed by two (2) CNAs (CNAs #1 and #3); however no one intervened to address the use of this restraint. (Refer to F225 and F226) The facility's failure to ensure residents were free from physical restraints imposed for purposes of discipline or convenience has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/21/14 and determined to exist on 11/19/14. The facility was notified of the Immediate Jeopardy on 11/21/14. An acceptable Allegation of Compliance (AoC) was received on 12/01/14 and the State Agency validated the Immediate Jeopardy was removed on 11/27/14, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Corrections (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy and procedure titled, Physical Restraint Reduction Program, effective 12/2010, revealed this facility's definition of physical restrain is any manual method or mechanical device, material or equipment attached adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include: Hand mitts, soft ties, or vest, lap cushions, lap trays that the resident cannot remove, a chair that prevents rising, tucking in or using velcro to hold a sheet, fabric or clothing tightly so that the resident's movement is restricted. Using devices in conjunction with a chair such as trays, table bars, belts, and/or side rails that the resident cannot remove easily that prevent resident from rising. Placing a chair or bed so close to the wall that the wall prevents a resident from rising out of the chair or voluntary getting out of the bed. Use of the physical restraint in this facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident or other residents and under the following conditions: As a last resort measure after a trail period where alternatives, less restrictive measures have been undertaken and proven to be unsuccessful; with a physician's orders [REDACTED]. Record review revealed the facility admitted Resident #4 on 11/05/14 with [DIAGNOSES REDACTED]. Review of admission Minimum Data Set (MDS) Assessment, dated 11/12/14, revealed the facility assessed Resident #4's cognition as severely impaired, with a Brief Interview of Mental Status (BIMS) score of 2 indicating the resident was non-interviewable Review of a physician's orders [REDACTED].#4 was to have an alarming seat belt for safety and to alert staff when the resident attempted to self transfer. The care plan goal for this resident was to be free from falls. Review of the facility's Initial Report, dated 11/19/14, revealed on 11/19/14 at 7:05 AM, Certified Nurse Aide (CNA) #1, who worked the 11:00 PM-7:00 AM shift, approached the Administrator to report Resident #4 had been observed secured to his/her wheelchair using a blanket. Review of CNA #1's written witness statement, dated 11/19/14, and interview with CNA #1, on 11/20/14 at 12:45 PM, revealed she was leaving for lunch at approximately 3:00 AM on 11/19/14, when she observed Resident #4 on Wing 2 tied in a wheelchair. When CNA #1 returned from lunch, at 3:30 AM, Resident #4 was still tied to the wheelchair in the hallway. Further interview with CNA #1 revealed Resident #4 was tied with a blanket which had 3 (three) knots which restricted the resident to the point he/she could barely lift his/her bottom up from his/her wheelchair. CNA #1 stated when she told Licensed Practical Nurse (LPN) #2, what she had observed, the LPN stated, it was against the law, . but what are we supposed to do. CNA #1 stated she also told LPN #4, the Charge Nurse, about what she had observed and he told her he knew she had taken a picture with her cell phone of Resident #4 being tied to the wheelchair. The Charge Nurse told her not to go back over on Wing 2 and . not get in the middle of the mess. CNA #1 stated the Director of Nursing (DON) and the Administrator were not available during the night, so she went immediately to the Administrator before she left work that morning. Interview with CNA #3, on 11/19/14 at 9:27 AM, revealed there was a blanket over the top of Resident #4's self-releasing seatbelt, almost all night long. She stated she did not consider it a restraint because it was not tied to the wheelchair, and the blanket kept the resident from pulling at the self-releasing belt all the time. CNA #3 revealed if she had seen it tied to the wheel chair she would have reported it to her Charge Nurse, but the blanket was not tied, it was just draped over the self-releasing seat belt. However, review of CNA #3's written witness statement, dated 11/19/14, revealed CNA #3 documented there was a sheet tied around Resident #4's waist, which was tied behind the wheel chair, rolled up like a belt. Further review of the statement revealed CNA #1 told CNA #3 that it was a restraint, and asked her did she know why it was a restraint and CNA #3 stated No. Interview with CNA #2, on 11/19/14 at 9:15 AM, revealed Resident #4 was in his/her wheelchair with a self-releasing seat belt and clip alarm on his/her person. CNA #2 stated the resident kept trying to release the belt and the alarm kept sounding so she took a blanket and tucked it over the self-releasing belt so Resident #4 would quit playing with the belt. CNA #2 stated it was not the first time she had hid the seat belt from Resident #4 to keep him/her from taking off the belt. She stated LPN #2 was aware she had to cover up Resident #4's belt. She stated she did not consider this a restraint, because the resident could still reach the belt, just not as often as before the blanket was applied. Review of LPN #2's written witness statement, dated 11/19/14, and interview with LPN #2, on 11/19/14 at 3:31 PM, revealed Resident #4 had a self-releasing seatbelt on his/her wheel chair, which the resident took off frequently. LPN #2 revealed the belt was not effective, but anything else would be considered a restraint and the facility was restraint-free. She stated the blanket was tucked under the resident's seat belt and it was not a restraint because it was not tied to the wheel chair. Review of LPN #4's witness statement, dated 11/19/14, revealed at approximately 4:35 AM on 11/19/14, CNA #1 stated she had a picture of a resident tied up. The CNA left and came back and said look at this. LPN #4 documented that he told CNA #1 to Come on and let us just get busy, we are way behind. Attempts to interview LPN #4 on 11/20/14 at 9:50 AM and 11:00 AM; and, on 11/21/14 at 9:58 AM were unsuccessful. Interview with the DON, on 11/21/14 at 11:10 AM, revealed she became aware of the allegation on 11/19/14, when speaking with the Administrator and the Corporate Nurse and she immediately began her investigation. The DON stated she would have expected any staff that had observed a resident with a sheet or blanket tied to a wheelchair to have reported it immediately, as this would be considered a restraint. Interview with the Administrator, on 11/21/14 at 11:30 AM, revealed he became aware of the allegation on 11/19/14, when CNA #1 came into his office and showed him three (3) photographs of Resident #4. The pictures revealed Resident #4 had a blanket draped over his/her lap to the sides of the wheelchair. The Administrator stated he was not sure if the blanket was tied to the axle or not, but it was bunched up at the end of the blanket and he could not see the resident's safety belt. He stated when he observed the blanket it was across the resident, and he felt the resident was being restrained. A post survey interview with the Administrator, conducted on 12/12/2014 at 8:13 AM, revealed through the facility's investigation he was unable to determine if Resident #4 was tied to his/her wheel chair; however, he did determine the resident was restrained because the blanket was covering the self releasing seat belt causing Resident #4 not to be able to release his/her self releasing seat belt.

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 0221 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 11/19/14, the facility suspended five (5) staff members: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4; and, on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. On 11/19/14, the Unit Manager (UM) assessed Resident #4 for any signs of injury and none were observed. The family and the physician were notified of the allegation on 11/19/14 by the ADON and initial reports were filed with the (State Survey Agency) SSA on 11/19/14 by the Administrator. 3. The Interdisciplinary Team (IDT) reassessed Resident #4 for the self-releasing seat belt and this was deemed to have been a restraint for this resident, due to the resident not being able to release the restraint on command. The family and physician were notified on 11/19/14, a consent form and a physician's orders [REDACTED]. 4. On 11/26/14, the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. The Social Services Director (SSD) assessed the resident for psychosocial harm and none was identified on 11/20/14-11/25/14. 6. Walking rounds were made twice each eight (8) hour shift to visually assess each resident for any restraint or potential restraint not previously assessed, or ordered by the physician and no concerns were identified. 7. All department heads (Administrator, DON, ADON, Unit Manager, Staff Development Coordinator {SDC}, SSD, Chaplain, Business Office Manager {BOM}, Dietary Manager, Rehabilitation Manager, MDS Coordinator, Quality of Life Director, and Human Resource Director {HRD}were educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights. A post-test was administered, with a required 100 percent (%) pass rate. 8. The HR Director was re-educated by the Chief Nurse Executive regarding back-ground checks and following the facility policy on 11/19/14. 9. On 11/19/14, the Regional HR Services performed 100% audit of criminal background results of all active employees from 04/2013 to present with no concerns noted. 10. All residents with any devices that could be categorized as a restraint were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications and none were identified. Care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. During walking rounds and audits it was discovered on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents have been reviewed or obtained. 12. On 11/26/14, education was provided to the Department Head Team by the Chief Nurse Executive regarding care plans, revision of the care plan and the role each nurse has in regard to updating and implementing appropriate interventions and a post test requiring 100% pass rate was required. 13. On 11/26/14, the IDT team made walking rounds on all residents and met to discuss interventions as it related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Care plans were reviewed and/or updated on 11/26/14 to include the new interventions if applicable. 14. Residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater were interviewed on 11/19/14, by the Administrator, DON, ADON, Chaplain and SSD regarding concerns with care or possible restraint activity and all concerns, most of which were concerning missing items, were reported to the SA. 15. A Resident Council Meeting was held on 11/19/14, to discuss abuse, neglect and resident rights. This meeting was reviewed by the Administrator for any concerns. 16. Head-to-toe skin assessments were conducted 11/19-20/14 by the ADON and UM for residents with a BIMS' score less than eight (8) with no concerns identified. 17. Interviews were conducted with family members of residents with a BIMS' score of less than eight (8) on 11/20/14 by the BOM, with no concerns identified. 18. Incident/Accident Reports for 08/01/14 through 11/20/14 were reviewed by the Nurse Consultant related to abuse, neglect, inappropriate restraints or violation of resident rights and no concerns were identified. 19. The Staff Development Coordinator provided education on abuse and neglect, restraints, cell phones, and resident rights to all staff working 11/19/14 and a post test, with a required 100 percent (%) pass rate was administered. Education on restraints was provided again on 11/25/14 to the DON, ADON, UM, MDS Coordinator, SDC, and Rehabilitation Manager by the Regional Program Manager. Staff not working on 11/19/14 will receive education and testing prior to working. Signs were posted at the time clock. 20. All staff working 11/19/14 were interviewed by the Administrator, DON, HR Coordinator and SDC in regards to any resident having been restrained and the findings were negative. 21. A new policy for review of potential employees was put into place on 11/19/14, utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work. 22. The HR Director received disciplinary action from the Administrator and the HR Regional Services on 11/22/14. 23. Orientation for all new staff will include education on abuse, resident rights, cell phone policy, restraints, care plan and revision of the care plan. A post test would be administered with a passing score of 100%. 24. Education was provided by the facility department heads to the nursing staff on 11/26/14, upon notification of the care plan deficiency. A post test was provided regarding care plans and revisions and interim care plans, interventions that should have been added that are specific to the resident's care and care plan policies prior to reporting to their assignments. A post test with a required passing grade of 100% was required. If 100% accuracy was not obtained, staff members were to be re-educated and re-tested until 100% was obtained. Staff not on duty 11/26/14 were to receive education, prior to working their next shift. Licensed staff was to update care plans during their shift for any resident changes, concerns with behaviors, removing their assistive devices, new orders, or any concerns with the resident's care, and to incorporate goals and objectives that would lead to the resident's highest obtainable level of independence. The Administrator would be responsible for checking all audits for any concerns. If concerns were identified, the Administrator was to act immediately. The Administrator or Department Heads or the RN Week-end Supervisor will be on site daily to review all audits and tests to identify any concerns to ensure all abuse, neglect, misappropriation, violation of resident rights, cell phone and restraint policies are being followed. A member of the regional staff or home office staff, Regional Nurse Special Projects, or Vice President of Operations were to have been on site daily until the immediacy was lifted and to ensure all audits and questionnaires were followed. If concerns were identified, the Administrator was to act immediately. 25. Walking rounds will be conducted two (2) times each eight (8) hour shift, for all residents, by the Department Managers to observe for abuse, neglect, misappropriation, violation of resident rights, cell phone and restraints, until the immediacy was lifted. During these rounds, two (2) staff members were to be tested regarding these issues and 100% accuracy was required or re-education was to have been administered. Also during the rounds, two (2) residents were to have been interviewed regarding any issues or concerns. Any violations of these policies was to have been addressed by ensuring the resident was safe, and reporting to the Charge Nurse, as well as the Administrator, per policy. Findings of all rounds and audits are to be reported to the DON and Administrator daily, who in turn are to report any concerns to the State Agencies and follow the abuse procedures and policies for reporting, protecting, etc. QA will review the results of all tests, interviews, and rounding observations to analyze results and determine if the frequency could have been reduced as well as any need for re-education. 26. The DON, ADON, or Staff Development Coordinator (SDC) will review the daily physician's orders [REDACTED]. 27. The IDT will hold daily meetings, beginning 11/26/14, in which a review of the twenty-four (24) hour nursing report for any changes of condition, any new admission, re-admission or concerns with the removal of assistive devices, as well as Physician Orders, for any changes or documentation requiring an interim care plan, a new care plan or a revision of the care plan. Care plans will be reviewed to ensure compliance, until the immediacy is lifted. Once the immediacy has been lifted, the IDT will continue to meet daily and ongoing for review of the care plans. 28. A QA meeting was conducted on 11/20/14, to discuss incidents as well as all education provided, assessments provided, assessments of all residents with devices, processes for restraints, employee files regarding any staff having been convicted of a felony and all reviewed with the Medical Director. 29. Weekly Quality Performance Improvement meetings with the Medical Director to be on-going. The meetings are to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings were to reviewed, trended and the committee would determine the course of action. **The State Survey Agency validated the corrective action taken by the facility on 12/04/14 as follows: 1. On 12/02/14, five (5) staff members' personnel files were reviewed: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4, regarding their written disciplinary actions, the restraint of Resident #4 and the failure to report abuse. The review also revealed on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. Review of the Resident #4's skin assessments, family and physician notification, care plan revision, ITP reviews of the seat-belt alarm restraint assessment, documentation and the physician order [REDACTED]. 3. Review of the Resident #4's care plan revisions, to include the use of the seat-belt, as a restraint device and alternate coping strategies when the resident became agitated, dated 11/19-26/14; consent for the use of restraints, dated 11/19/14; physician's orders [REDACTED]. 4. Review of the IDT Notes and Comprehensive Care Plan

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F 0221 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) for At Risk for Harm/Injury, related to the seat belt, dated 11/19/14 and the Resident At Risk for and/or Expressing Anxiety Care Plan, dated 11/19/14 and interventions, dated 11/26/14, revealed the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. Review of the Social Services Progress Notes, dated 11/20/14-11/25/14, revealed the Social Service Director (SSD) assessed the resident daily for psychosocial harm and no concerns were identified. 6. Review of the Instructions for Walking Rounds and Audit Sheets, dated 11/19/14 through 12/01/14 revealed walking rounds were completed twice each eight (8) hour shift to identify if there were any restraints or potential restraints. No concerns were identified. 7. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with the Administrator and Director of Nursing (DON) at 12:45 PM, the HR Director at 3:35 PM and LPN #6 at 3:50 PM revealed they had been inserviced and were educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights, a post-test was administered, with a required 100 percent (%) pass rate and all stated they had been inserviced and passed the test, with a 100 % pass rate. 8. Interview with the HR Director, on 12/02/14 at 3:35 PM, revealed she had been educated on the new policy for review of potential employees, put into place on 11/19/14 and utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications that would be reviewed by the HR Director for eligibility. Further interview revealed the Administrator would complete the final review, before a potential employee would be allowed to work. 9. Review of the Audit Records, dated 11/19/14, revealed no concerns. Review of Personnel records revealed LPN #1 was terminated on 11/19/14, for falsification of the application for employment, regarding not having any felony on her records and review of the result of the audit for personnel records, back to 2003 and a review of the Policy for Criminal Background Checks, dated 11/19/14, revealed no other concerns were identified. 10. Review of the Instructions for Walking Rounds and the 100% Visual Audit Tool, dated 11/19-24/14, revealed all residents with any devices that could be categorized as a restraint, were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications. No concerns were identified. 100% audits of all resident's care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. A review of the 100% audits, dated 11/19-24/14, completed during walking rounds, revealed on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts, which were made and installed by the manufacturer of the electric wheel chair, had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents were reviewed or obtained, as evidenced by review of Resident #1's and Resident B's records. It was determined, per the Pre-Restraining Evaluation, dated 11/25/14, these were not restraints for these residents. 12. Review of Post Testing, dated 11/20-25/14, The Healthcare-In-Service Sign-In Sheets for Department Heads, dated 11/19/14, and interviews on 12/02/14 with the HRD at 3:35 PM, the ADON at 3:50 PM, and the Administrator and DON at 12:45 PM, revealed the Department Heads were educated on care plans, revision of the care plan and each nurse's role in regard to updating and implementing appropriate interventions. A post test requiring 100% pass rate was required. 13. Review of the 11/25-26/14 Census Board Audit Sheets revealed the IDT team made walking rounds, and completed them on all residents. Review of the IDT meeting notes, dated 11/25-26/14 revealed they met to discuss interventions related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Review of Care plans for Unsampled Residents B, C, D, E, and F, who required alarms, revealed they were reviewed and/or updated on 11/26/14 to include the new interventions. 14. Verified with the SSA Complaints Coordinator any concerns identified during the facility's resident interviews, were received on 12/01/14 and she was waiting on the final reports. Interviews conducted on 12/03/14 with Unsampled Resident B, at 9:25 AM; Resident C at 1:35 PM; Resident D, at 11:00 AM; Resident E, at 2:50 PM; and, Resident F, at 12:00 PM, revealed no concerns with resident care, abuse, neglect or any restraint activity. 15. Review of the Resident Council Minutes, dated 11/19/14, revealed the residents were educated on abuse, neglect, restraints and reporting these concern to staff and the DON and Administrator. 16. Review of five (5) residents with head-to-toe skin assessments, who were assessed to have a BIMS' score less than eight (8), revealed the assessments were completed by the ADON and UM, on 11/19/14. No concerns were identified. 17. Review of the family contacts for five (5) family members of residents, with a BIMS' score of less than eight (8) revealed they were completed on 11/20/14 by the BOM. No concerns were identified. Interview with a family member for Resident #4, on 11/21/14 at 2:30 PM, revealed no concerns. 18. Incident/Accident Reports dated 08/01/14 through 11/20/14 were reviewed related to abuse, neglect, inappropriate restraints or violation of resident rights. No concerns were identified. 19. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, and CNA #14 at 5:00 PM; and, on 12/04/14 with LPN #7 at 8:02 AM; CNA #15 at 7:45 AM and CNA #16, at 8:00 AM, revealed they were educated and tested on abuse and neglect, restraints, cell phones, and resident rights. 20. Review of the staff's written statements, dated 11/19/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and DON at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16, at 8:00 AM, revealed all were aware of the definition of restraints and abuse. 21. Review of the facility's general orientation policy utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work, was reviewed with no concerns. Review of the facility's policy for Pre-Hire Check List, dated 11/19/14, revealed it included a clause regarding the Administrator's final review before the potential employee is allowed to work. 22 Review of the written reprimand for the HRD on 11/22/14 and interview with the HRD, on 12/02/14 at 3:35 PM revealed she had training on the new policy and check list and the Administrator had to sign-off on this, prior to anyone being hired. Interview with the Administrator, on 12/02/14 at 8:35 AM revealed they had a double check system now and there should be no other problems with screening of employees, prior to hiring. 23. A review of the Orientation Packet on 12/03/14, with policies to include: Abuse Prevention Policy and Procedure, dated April 2013; Health Insurance Portability and Accountability Act (HIPAA) Policy, undated; Resident Rights, undated; Restraint Reduction, dated 12/20/10; Social Media, dated 03/01/13; Care Planning, dated October 2013; Change in a Resident's Condition, dated October 2013; Goals and Objectives of the Care Plans, dated April 2011; Resident/ Family Participation in the Care Plan, dated December 2006; and Usage of the Care Plan, dated August 2006, revealed no concerns. 24. Review of auditing and testing records, dated 11/19/14 through 12/02/14, used to ensure all abuse, neglect, misappropriation, violation of resident rights, cell phone use and restraint policies were being followed, revealed no concerns. Care plan education and testing was provided to staff on 11/26/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and the DON on at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16 at 8:00 AM, revealed all were aware of the definition of restraints and abuse, when and to whom they were to report these things and all had education on the care plans. A review of pre-testing and post-tests administered 11/20-26/14, revealed no concerns. 25. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three (3) QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 26. Review of the audit sheets for Residents With Assistive Devices, Daily Clinical Meetings; Walking Rounds and Testing of Staff, dated 11/19/14 through 12/01/14, revealed no concerns. 27. Review of the daily IDT records for 11/26/14-12/01/14, audits for residents with any assistive devices, 24 Hour Reports Reviews, physician's orders [REDACTED]. 28. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 29. Interviews with the Administrator on 12/02/14 at 8:35 AM and the DON on 12/04/14 at 10:35 AM, revealed the weekly Quality Performance Improvement meetings with the Medical Director would be on-going and the meetings were to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings would be reviewed, trended and the committee would determine the course of action. Interviews with the DON on 12/02/14 at 8:35 AM; and, on 12/04/14 at 10:35 AM, revealed the IDT will continue an on-going weekly assessment to review all devices and restraints for the continued need, reduction attempt or elimination.
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**

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	185195	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKVIEW NURSING & REHABILITATION CENTER	10456 US HWY 62 CALVERT CITY, KY 42029

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) **mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of witness statements, personnel records, a Backgound Summary Report and the facility's policy and procedure, it was determined the facility failed to have an effective system to ensure staff reported observed incidents of abuse and/or mistreatment to the facility's Administrator for one (1) of fifteen (15) sampled residents (Resident #4). In addition, the facility failed to make reasonable efforts to uncover information about any past criminal prosecutions for one (1) staff member, LPN #1, related to felony charges. On 11/19/14, Certified Nurse Aide (CNA) #1 and CNA #3 observed Resident #4 in his/her wheelchair with a blanket or sheet, tied around the resident's waist and secured to the back of his/her wheel chair. CNA #1 reported what she had observed to Licensed Practical Nurse (LPN) #2 and LPN #4; however, no action was taken. The Administrator was not made aware of the situation until CNA #1 reported it to the Administrator at the end of her shift, approximately four (4) hours later. (Refer to F221) The facility's failure to ensure staff reported observed incidents of abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 11/21/14 and determined to exist on 11/19/14. The facility was notified of the Immediate Jeopardy on 11/21/14. An acceptable Allegation of Compliance (AoC) was received on 12/01/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/27/14, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC); and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: 1. Review of the facility's Policy and Procedure titled, Abuse, Neglect and Misappropriation, dated April 2013, revealed . all allegations of abuse are to be reported immediately to the Charge Nurse. If the person reporting the abuse believes there is a lack of response from the Charge Nurse, the person will then notify the Director of Nursing (DON) and/or Administrator. If the DON and/or Administrator are not in the facility, staff will notify them by phone. The Charge Nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee, pending the outcome of the investigation. Interviews on 11/20/14 at 12:45 PM with CNA #1, on 11/19/14 at 9:27 AM with CNA #3, on 11/19/14 at 3:31 with LPN #2 and on 11/21/14 at 11:10 with LPN #4 and review of their witness statements revealed on 11/19/14 CNA #1 and CNA #4 observed Resident #4 on the hall in his/her wheelchair with a self-releasing seat belt and clip alarm on his/her person. There was a blanket/sheet wrapped around the resident's waist and secured to the back of the resident's wheelchair. CNA #1 reported what she had witnessed to LPN #2 and LPN #4; however, the abuse was not reported to the Administrator and/or DON until CNA #1 reported it to the Administrator at the end of her shift, approximately four (4) hours after the resident was observed secured to his/her wheelchair. Interview with CNA #1, on 11/20/14 at 12:45 PM, revealed she told LPN #2, what she had observed and the LPN stated, It was against the law. But what are we supposed to do. CNA #1 stated she also told LPN #4, the Charge Nurse about what she had observed and LPN #4 told her he knew she had taken a picture with her cell phone of Resident #4 being tied to the wheelchair. The CNA stated the Charge Nurse then told her not to go back over on Wing 2 and . not get in the middle of the mess. CNA #1 stated the DON and the Administrator were not available during the night, so she went immediately to the Administrator before she left work that morning. Interview with CNA #3, on 11/19/14 at 9:27 AM, revealed she had been trained on abuse/neglect but she did not report this to her Charge Nurse immediately because she did not think this was abuse. Interview with LPN #2, on 11/19/14 at 3:31 PM, revealed she was aware the blanket was tucked under the resident's seat belt. LPN #2 stated she did not report it because she did not consider it abuse. LPN #2 revealed she had received training on the facility's policy on abuse/neglect. Review of LPN #4's witness statement, dated 11/19/14, revealed at approximately 4:35 AM on 11/19/14, CNA #1 stated she had a picture of a resident tied up. The CNA left and came back and asked LPN #4 to look at the picture. Further review revealed LPN #4 documented that she told CNA #1 to Come on and let us just get busy, we are way behind. There was no documented evidence LPN #4 reported the abuse to the Administrator or DON or took any actions to intervene. Attempts to interview LPN #4 on 11/20/14 at 9:50 AM and 11:00 AM; and, on 11/21/14 at 9:58 AM were unsuccessful. Interview with the DON, on 11/21/14 at 11:10 AM, revealed she became aware of the allegation on 11/19/14, when speaking with the Administrator and the Corporate Nurse and she immediately began her investigation regarding the allegation of abuse towards Resident #4. The DON stated she would have expected any staff that had observed a resident with a sheet or blanket tied to a wheelchair, would have reported this immediately, as this would be considered abuse. Interview with the Administrator, on 11/21/14 at 11:30 AM, revealed he became aware of the allegation on 11/19/14, when CNA #1 came into his office and showed him three (3) photographs of Resident #4. The pictures revealed Resident #4 had a blanket draped over his/her lap to the sides of the wheelchair. The Administrator stated he was not sure if the blanket was tied to the axle or not, but it was bunched up at the end of the blanket and he could not see the resident's safety belt. Further interview with the Administrator revealed he would expect that if anyone had seen this type of abuse it should have been reported immediately. 2. Review of the facility's policy for Criminal Background Checks, dated 10/01/09, revealed, A criminal background check will be completed for each state and or county of residence during the past seven (7) years. The check must be done post offer and cleared prior to the stakeholder (staff member) beginning work, no exceptions. HR (Human Resources) will access and review the findings of the Criminal Background Checks and stakeholders who have been convicted of, or entered a plea of no contest, or guilty to, any of the following crimes will not be eligible for initial or continued employment with the company. The crimes included theft, robbery and related crimes, if the offense was a felony; sale, manufacture, delivery or possession with an intent to sell, manufacture, deliver or use of controlled substances or counterfeit controlled substances, if the offense was a felony; forgery or uttering forged instruments; and fraud in obtaining medicinal drugs. Review of LPN #1's Personnel Record revealed she was hired, by the facility, on 11/03/14. Review of the Statewide Criminal Background Report Summary, dated 10/21/14, revealed the staff member's results were "decisional, and required further review to determine the staff member's eligibility for hire, based on background check results. The facility was to have reviewed the corresponding detailed component report section for additional information. Review of the Background Summary Report, dated 10/21/14, revealed the LPN was found guilty of a felony, on 05/08/09 and the charge was obtaining a controlled substance by fraud, making a false statement and a forgery attempt. The LPN was credited for two (2) days time served; a two year prison sentence was suspended; and, the LPN was on probation for two years. Review of the staff member's employment application, dated 09/03/14, revealed the question have you ever been convicted of, pled guilty or nolo contendere or had adjudication withheld by the court, judge or jury for a crime that is a felony or a first degree misdemeanor? to which the LPN's written response was no. Interview with the Human Resources (HR) Director, on 11/20/14 at 12:50 PM, who stated she was the only one responsible to review the application and the background checks, prior to hiring any staff member, revealed she failed to fully review the Criminal Background Report Summary, prior to hiring LPN #1. She stated she was not aware LPN #1 had a prior felony charge. Interview with the Administrator, on 11/20/14 at 2:10 PM, revealed he was also unaware of the charges, as this part of the application process was left up to the HR Director. After review of the background checks and the application process, the Administrator terminated LPN #1 on 11/19/14, for making a false statement on her application for employment. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 11/19/14, the facility suspended five (5) staff members: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4; and, on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. On 11/19/14, the Unit Manager (UM) assessed Resident #4 for any signs of injury and none were observed. The family and the physician were notified of the allegation on 11/19/14 by the ADON and initial reports were filed with the (State Survey Agency) SSA on 11/19/14 by the Administrator. 3. The Interdisciplinary Team (IDT) reassessed Resident #4 for the self-releasing seat belt and this was deemed to have been a restraint for this resident, due to the resident not being able to release the restraint on command. The family and physician were notified on 11/19/14, a consent form and a physician's orders [REDACTED]. 4. On 11/26/14, the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. The Social Services Director (SSD) assessed the resident for psychosocial harm and none was identified on 11/20/14-11/25/14. 6. Walking rounds were made twice each eight (8) hour shift to visually assess each resident for any restraint or potential restraint not previously assessed, or ordered by the physician and no concerns were identified. 7. All department heads (Administrator, DON, ADON, Unit Manager, Staff Development Coordinator {SDC}, SSD, Chaplain, Business Office Manager {BOM}, Dietary Manager, Rehabilitation Manager, MDS Coordinator, Quality of Life Director, and Human Resource Director {HRD}were

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights. A post-test was administered, with a required 100 percent (%) pass rate. 8. The HR Director was re-educated by the Chief Nurse Executive regarding back-ground checks and following the facility policy on 11/19/14. 9. On 11/19/14, the Regional HR Services performed 100% audit of criminal background results of all active employees from 04/2013 to present with no concerns noted. 10. All residents with any devices that could be categorized as a restraint were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications and none were identified. Care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. During walking rounds and audits it was discovered on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents have been reviewed or obtained. 12. On 11/26/14, education was provided to the Department Head Team by the Chief Nurse Executive regarding care plans, revision of the care plan and the role each nurse has in regard to updating and implementing appropriate interventions and a post test requiring 100% pass rate was required. 13. On 11/26/14, the IDT team made walking rounds on all residents and met to discuss interventions as it related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Care plans were reviewed and/or updated on 11/26/14 to include the new interventions if applicable. 14. Residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater were interviewed on 11/19/14, by the Administrator, DON, ADON, Chaplain and SSD regarding concerns with care or possible restraint activity and all concerns, most of which were concerning missing items, were reported to the SA. 15. A Resident Council Meeting was held on 11/19/14, to discuss abuse, neglect and resident rights. This meeting was reviewed by the Administrator for any concerns. 16. Head-to-toe skin assessments were conducted 11/19-20/14 by the ADON and UM for residents with a BIMS' score less than eight (8) with no concerns identified. 17. Interviews were conducted with family members of residents with a BIMS' score of less than eight (8) on 11/20/14 by the BOM, with no concerns identified. 18. Incident/Accident Reports for 08/01/14 through 11/20/14 were reviewed by the Nurse Consultant related to abuse, neglect, inappropriate restraints or violation of resident rights and no concerns were identified. 19. The Staff Development Coordinator provided education on abuse and neglect, restraints, cell phones, and resident rights to all staff working 11/19/14 and a post test, with a required 100 percent (%) pass rate was administered. Education on restraints was provided again on 11/25/14 to the DON, ADON, UM, MDS Coordinator, SDC, and Rehabilitation Manager by the Regional Program Manager. Staff not working on 11/19/14 will receive education and testing prior to working. Signs were posted at the time clock. 20. All staff working 11/19/14 were interviewed by the Administrator, DON, HR Coordinator and SDC in regards to any resident having been restrained and the findings were negative. 21. A new policy for review of potential employees was put into place on 11/19/14, utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work. 22. The HR Director received disciplinary action from the Administrator and the HR Regional Services on 11/22/14. 23. Orientation for all new staff will include education on abuse, resident rights, cell phone policy, restraints, care plan and revision of the care plan. A post test would be administered with a passing score of 100%. 24. Education was provided by the facility department heads to the nursing staff on 11/26/14, upon notification of the care plan deficiency. A post test was provided regarding care plans and revisions and interim care plans, interventions that should have been added that are specific to the resident's care and care plan policies prior to reporting to their assignments. A post test with a required passing grade of 100% was required. If 100% accuracy was not obtained, staff members were to be re-educated and re-tested until 100% was obtained. Staff not on duty 11/26/14 were to receive education, prior to working their next shift. Licensed staff was to update care plans during their shift for any resident changes, concerns with behaviors, removing their assistive devices, new orders, or any concerns with the resident's care, and to incorporate goals and objectives that would lead to the resident's highest obtainable level of independence. The Administrator would be responsible for checking all audits for any concerns. If concerns were identified, the Administrator was to act immediately. The Administrator or Department Heads or the RN Week-end Supervisor will be on site daily to review all audits and tests to identify any concerns to ensure all abuse, neglect, misappropriation, violation of resident rights, cell phone and restraint policies are being followed. A member of the regional staff or home office staff, Regional Nurse Special Projects, or Vice President of Operations were to have been on site daily until the immediacy was lifted and to ensure all audits and questionnaires were followed. If concerns were identified, the Administrator was to act immediately. 25. Walking rounds will be conducted two (2) times each eight (8) hour shift, for all residents, by the Department Managers to observe for abuse, neglect, misappropriation, violation of resident rights, cell phone and restraints, until the immediacy was lifted. During these rounds, two (2) staff members were to be tested regarding these issues and 100% accuracy was required or re-education was to have been administered. Also during the rounds, two (2) residents were to have been interviewed regarding any issues or concerns. Any violations of these policies was to have been addressed by ensuring the resident was safe, and reporting to the Charge Nurse, as well as the Administrator, per policy. Findings of all rounds and audits are to be reported to the DON and Administrator daily, who in turn are to report any concerns to the State Agencies and follow the abuse procedures and policies for reporting, protecting, etc. QA will review the results of all tests, interviews, and rounding observations to analyze results and determine if the frequency could have been reduced as well as any need for re-education. 26. The DON, ADON, or Staff Development Coordinator (SDC) will review the daily physician's orders [REDACTED]. 27. The IDT will hold daily meetings, beginning 11/26/14, in which a review of the twenty-four (24) hour nursing report for any changes of condition, any new admission, re-admission or concerns with the removal of assistive devices, as well as Physician Orders, for any changes or documentation requiring an interim care plan, a new care plan or a revision of the care plan. Care plans will be reviewed to ensure compliance, until the immediacy is lifted. Once the immediacy has been lifted, the IDT will continue to meet daily and ongoing for review of the care plans. 28. A QA meeting was conducted on 11/20/14, to discuss incidents as well as all education provided, assessments provided, assessments of all residents with devices, processes for restraints, employee files regarding any staff having been convicted of a felony and all reviewed with the Medical Director. 29. Weekly Quality Performance Improvement meetings with the Medical Director to be on-going. The meetings are to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings were to reviewed, trended and the committee would determine the course of action. **The State Survey Agency validated the corrective action taken by the facility on 12/04/14 as follows: 1. On 12/02/14, five (5) staff members' personnel files were reviewed: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4, regarding their written disciplinary actions, the restraint of Resident #4 and the failure to report abuse. The review also revealed on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. Review of the Resident #4's skin assessments, family and physician notification, care plan revision, ITP reviews of the seat-belt alarm restraint assessment, documentation and the physician order [REDACTED]. 3. Review of the Resident #4's care plan revisions, to include the use of the seat-belt, as a restraint device and alternate coping strategies when the resident became agitated, dated 11/19-26/14; consent for the use of restraints, dated 11/19/14; physician's orders [REDACTED]. 4. Review of the IDT Notes and Comprehensive Care Plan for At Risk for Harm/Injury, related to the seat belt, dated 11/19/14 and the Resident At Risk for and/or Expressing Anxiety Care Plan, dated 11/19/14 and interventions, dated 11/26/14, revealed the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. Review of the Social Services Progress Notes, dated 11/20/14-11/25/14, revealed the Social Service Director (SSD) assessed the resident daily for psychosocial harm and no concerns were identified. 6. Review of the Instructions for Walking Rounds and Audit Sheets, dated 11/19/14 through 12/01/14 revealed walking rounds were completed twice each eight (8) hour shift to identify if there were any restraints or potential restraints. No concerns were identified. 7. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with the Administrator and Director of Nursing (DON) at 12:45 PM, the HR Director at 3:35 PM and LPN #6 at 3:50 PM revealed they had been inserviced and were educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights, a post-test was administered, with a required 100 percent (%) pass rate and all stated they had been inserviced and passed the test, with a 100 % pass rate. 8. Interview with the HR Director, on 12/02/14 at 3:35 PM, revealed she had been educated on the new policy for review of potential employees, put into place on 11/19/14 and utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications that would be reviewed by the HR Director for eligibility. Further interview revealed the Administrator would

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 5) complete the final review, before a potential employee would be allowed to work. 9. Review of the Audit Records, dated 11/19/14, revealed no concerns. Review of Personnel records revealed LPN #1 was terminated on 11/19/14, for falsification of the application for employment, regarding not having any felony on her records and review of the result of the audit for personnel records, back to 2003 and a review of the Policy for Criminal Background Checks, dated 11/19/14, revealed no other concerns were identified. 10. Review of the Instructions for Walking Rounds and the 100% Visual Audit Tool, dated 11/19-24/14, revealed all residents with any devices that could be categorized as a restraint, were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications. No concerns were identified. 100% audits of all resident's care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. A review of the 100% audits, dated 11/19-24/14, completed during walking rounds, revealed on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts, which were made and installed by the manufacturer of the electric wheel chair, had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents were reviewed or obtained, as evidenced by review of Resident #1's and Resident B's records. It was determined, per the Pre-Restraining Evaluation, dated 11/25/14, these were not restraints for these residents. 12. Review of Post Testing, dated 11/20-25/14, The Healthcare-In-Service Sign-In Sheets for Department Heads, dated 11/19/14, and interviews on 12/02/14 with the HRD at 3:35 PM, the ADON at 3:50 PM, and the Administrator and DON at 12:45 PM, revealed the Department Heads were educated on care plans, revision of the care plan and each nurse's role in regard to updating and implementing appropriate interventions. A post test requiring 100% pass rate was required. 13. Review of the 11/25-26/14 Census Board Audit Sheets revealed the IDT team made walking rounds, and completed them on all residents. Review of the IDT meeting notes, dated 11/25-26/14 revealed they met to discuss interventions related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Review of Care plans for Unsampled Residents B, C, D, E, and F, who required alarms, revealed they were reviewed and/or updated on 11/26/14 to include the new interventions. 14. Verified with the SSA Complaints Coordinator any concerns identified during the facility's resident interviews, were received on 12/01/14 and she was waiting on the final reports. Interviews conducted on 12/03/14 with Unsampled Resident B, at 9:25 AM; Resident C at 1:35 PM; Resident D, at 11:00 AM; Resident E, at 2:50 PM; and, Resident F, at 12:00 PM, revealed no concerns with resident care, abuse, neglect or any restraint activity. 15. Review of the Resident Council Minutes, dated 11/19/14, revealed the residents were educated on abuse, neglect, restraints and reporting these concern to staff and the DON and Administrator. 16. Review of five (5) residents with head-to-toe skin assessments, who were assessed to have a BIMS' score less than eight (8), revealed the assessments were completed by the ADON and UM, on 11/19/14. No concerns were identified. 17. Review of the family contacts for five (5) family members of residents, with a BIMS' score of less than eight (8) revealed they were completed on 11/20/14 by the BOM. No concerns were identified. Interview with a family member for Resident #4, on 11/21/14 at 2:30 PM, revealed no concerns. 18. Incident/Accident Reports dated 08/01/14 through 11/20/14 were reviewed related to abuse, neglect, inappropriate restraints or violation of resident rights. No concerns were identified. 19. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, and CNA #14 at 5:00 PM; and, on 12/04/14 with LPN #7 at 8:02 AM; CNA #15 at 7:45 AM and CNA #16, at 8:00 AM, revealed they were educated and tested on abuse and neglect, restraints, cell phones, and resident rights. 20. Review of the staff's written statements, dated 11/19/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and DON at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16, at 8:00 AM, revealed all were aware of the definition of restraints and abuse. 21. Review of the facility's general orientation policy utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work, was reviewed with no concerns. Review of the facility's policy for Pre-Hire Check List, dated 11/19/14, revealed it included a clause regarding the Administrator's final review before the potential employee is allowed to work. 22 Review of the written reprimand for the HRD on 11/22/14 and interview with the HRD, on 12/02/14 at 3:35 PM revealed she had training on the new policy and check list and the Administrator had to sign-off on this, prior to anyone being hired. Interview with the Administrator, on 12/02/14 at 8:35 AM revealed they had a double check system now and there should be no other problems with screening of employees, prior to hiring. 23. A review of the Orientation Packet on 12/03/14, with policies to include: Abuse Prevention Policy and Procedure, dated April 2013; Health Insurance Portability and Accountability Act (HIPAA) Policy, undated; Resident Rights, undated; Restraint Reduction, dated 12/20/10; Social Media, dated 03/01/13; Care Planning, dated October 2013; Change in a Resident's Condition, dated October 2013; Goals and Objectives of the Care Plans, dated April 2011; Resident/ Family Participation in the Care Plan, dated December 2006; and Usage of the Care Plan, dated August 2006, revealed no concerns. 24. Review of auditing and testing records, dated 11/19/14 through 12/02/14, used to ensure all abuse, neglect, misappropriation, violation of resident rights, cell phone use and restraint policies were being followed, revealed no concerns. Care plan education and testing was provided to staff on 11/26/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and the DON on at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16 at 8:00 AM, revealed all were aware of the definition of restraints and abuse, when and to whom they were to report these things and all had education on the care plans. A review of pre-testing and post-tests administered 11/20-26/14, revealed no concerns. 25. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three (3) QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 26. Review of the audit sheets for Residents With Assistive Devices, Daily Clinical Meetings; Walking Rounds and Testing of Staff, dated 11/19/14 through 12/01/14, revealed no concerns. 27. Review of the daily IDT records for 11/26/14-12/01/14, audits for residents with any assistive devices, 24 Hour Reports Reviews, physician's orders [REDACTED]. 28. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 29. Interviews with the Administrator on 12/02/14 at 8:35 AM and the DON on 12/04/14 at 10:35 AM, revealed the weekly Quality Performance Improvement meetings with the Medical Director would be on-going and the meetings were to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings would be reviewed, trended and the committee would determine the course of action. Interviews with the DON on 12/02/14 at 8:35 AM; and, on 12/04/14 at 10:35 AM, revealed the IDT will continue an on-going weekly assessment to review all devices and restraints for the continued need, reduction attempt or elimination.
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 witness statements and the facility's policy and procedure it was determined the facility failed to implement its Abuse, Neglect and Misappropriation, policy and procedure for one (1) of fifteen (15) sampled residents (Resident #4). On 11/19/14, Resident #4 was seated in the hallway in a wheelchair. A blanket or sheet was observed by Certified Nurse Aide (CNA) #1 and CNA #3 wrapped across the resident's waist and secured to the back of the wheelchair. CNA #1 reported the incident to LPN #2 and LPN #4, who were in charge; however, the incident was not reported to the Administrator or the Director of Nursing immediately per the facility's policy and procedure. CNA #1 reported the incident to the Administrator at the end of her shift, approximately four (4) hours later. (Refer to F221 and F225) The facility's failure to ensure staff reported observed incidents of abuse, neglect, and mistreatment per the facility policy and procedure has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 11/21/14 and determined to exist on 11/19/14. The facility was notified of the Immediate Jeopardy on 11/21/14. An acceptable Allegation of Compliance (AoC) was received on 12/01/14 and the State Agency validated the Immediate Jeopardy was removed on 11/27/14, as alleged. The scope and Severity was lowered to a D while the facility develops and implements the Plan of Corrections (PoC); and the facility's Quality Assurance (QA) monitors the

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	185195	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) effectiveness of the systemic changes. The findings include: Review of the facility's Policy and Procedure titled, Abuse, Neglect and Misappropriation, dated April 2013, revealed All allegations of abuse are to be reported immediately to the Charge Nurse. If the person reporting the abuse believes there is a lack of response from the charge nurse, the person will then notify the DON and/or Administrator. If the DON and/ or Administrator are not in the facility, staff will notify them by phone. The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee, pending the outcome of the investigation. Interviews on 11/20/14 at 12:45 PM with CNA #1, on 11/19/14 at 9:27 AM with CNA #3, on 11/19/14 at 3:31 with LPN #2 and on 11/21/14 at 11:10 with LPN #4 and review of witness statements revealed on 11/19/14, CNA #1 and CNA #3 witnessed Resident #4 with a blanket/sheet wrapped around his/her waist. The blanket/sheet was secured to the back of the resident's wheelchair. CNA #1 reported what she had witnessed to LPN #2 and her Charge Nurse (LPN #4); however, the abuse was not reported to the Administrator and/or DON immediately per the facility's policy and procedure. CNA #1 reported the incident to the Administrator at the end of his/her shift, which was approximately four (4) hours after the resident was observed. Interview with CNA #2, on 11/19/14 at 9:15 AM, revealed Resident #4 was in his/her wheelchair and kept releasing the self-release seatbelt causing it to alarm so she took a blanket and tucked it over the self-releasing belt so Resident #4 would quit playing with the belt. CNA #2 stated this was not the first time she had hid the seat belt from Resident #4 to keep him/her from taking off the belt. She stated LPN #2 was aware she had to cover up Resident #4's belt. Interview with CNA #1, on 11/20/14 at 12:45 PM, revealed she told LPN #2 and LPN #4 about Resident #4 being tied to the wheelchair but no action was taken. CNA #1 stated the DON and the Administrator were not available during the night, so she went immediately to the Administrator before she left work that morning. She stated she was not aware she was supposed to call the Administrator or DON when they were not in the building. Interview with CNA #3, on 11/19/14 at 9:27 AM, revealed she witnessed a blanket wrapped around Resident #4's seatbelt. However, she did not immediately report this to her Charge Nurse, per the facility's policy because she did not consider it abuse. Interview with LPN #2, on 11/19/14 at 3:31 PM, revealed she was aware the blanket was tucked under the resident's seat belt. Further interview revealed she also did not immediately report the incident, as she should have per facility policy. LPN #2 stated she had been trained on the facility's abuse/neglect policy but did not report the incident because she did not consider it abuse. Review of LPN #4's witness statement, dated 11/19/14, revealed at approximately 4:35 AM on 11/19/14, CNA #1 stated she had a picture of a resident tied up. There was no documented evidence LPN #4 reported the abuse to the Administrator and/or the DON immediately per the facility's policy and procedure. Unsuccessful attempts to interview LPN #4 were made on 11/20/14 at 9:50 AM and 11:00 AM; and, on 11/21/14 at 9:58 AM. Interview with the DON on 11/21/14 at 11:05 PM, revealed she would expect any staff, who witnessed or suspected any signs of abuse to report it immediately to their Charge Nurse on duty and to follow up through the chain of command, per the facility's policy. Interview with the Administrator on 11/21/14 at 11:30 AM, revealed he would have expected any staff that saw or suspected any signs of abuse to report immediately to their immediate supervisor per facility policy. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 11/19/14, the facility suspended five (5) staff members: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4; and, on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. On 11/19/14, the Unit Manager (UM) assessed Resident #4 for any signs of injury and none were observed. The family and the physician were notified of the allegation on 11/19/14 by the ADON and initial reports were filed with the (State Survey Agency) SSA on 11/19/14 by the Administrator. 3. The Interdisciplinary Team (IDT) reassessed Resident #4 for the self-releasing seat belt and this was deemed to have been a restraint for this resident, due to the resident not being able to release the restraint on command. The family and physician were notified on 11/19/14, a consent form and a physician's orders [REDACTED]. 4. On 11/26/14, the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. The Social Services Director (SSD) assessed the resident for psychosocial harm and none was identified on 11/20/14-11/25/14. 6. Walking rounds were made twice each eight (8) hour shift to visually assess each resident for any restraint or potential restraint not previously assessed, or ordered by the physician and no concerns were identified. 7. All department heads (Administrator, DON, ADON, Unit Manager, Staff Development Coordinator {SDC}, SSD, Chaplain, Business Office Manager {BOM}, Dietary Manager, Rehabilitation Manager, MDS Coordinator, Quality of Life Director, and Human Resource Director {HRD}were educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights. A post-test was administered, with a required 100 percent (%) pass rate. 8. The HR Director was re-educated by the Chief Nurse Executive regarding back-ground checks and following the facility policy on 11/19/14. 9. On 11/19/14, the Regional HR Services performed 100% audit of criminal background results of all active employees from 04/2013 to present with no concerns noted. 10. All residents with any devices that could be categorized as a restraint were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications and none were identified. Care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. During walking rounds and audits it was discovered on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents have been reviewed or obtained. 12. On 11/26/14, education was provided to the Department Head Team by the Chief Nurse Executive regarding care plans, revision of the care plan and the role each nurse has in regard to updating and implementing appropriate interventions and a post test requiring 100% pass rate was required. 13. On 11/26/14, the IDT team made walking rounds on all residents and met to discuss interventions as it related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Care plans were reviewed and/or updated on 11/26/14 to include the new interventions if applicable. 14. Residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater were interviewed on 11/19/14, by the Administrator, DON, ADON, Chaplain and SSD regarding concerns with care or possible restraint activity and all concerns, most of which were concerning missing items, were reported to the SA. 15. A Resident Council Meeting was held on 11/19/14, to discuss abuse, neglect and resident rights. This meeting was reviewed by the Administrator for any concerns. 16. Head-to-toe skin assessments were conducted 11/19-20/14 by the ADON and UM for residents with a BIMS' score less than eight (8) with no concerns identified. 17. Interviews were conducted with family members of residents with a BIMS' score of less than eight (8) on 11/20/14 by the BOM, with no concerns identified. 18. Incident/Accident Reports for 08/01/14 through 11/20/14 were reviewed by the Nurse Consultant related to abuse, neglect, inappropriate restraints or violation of resident rights and no concerns were identified. 19. The Staff Development Coordinator provided education on abuse and neglect, restraints, cell phones, and resident rights to all staff working 11/19/14 and a post test, with a required 100 percent (%) pass rate was administered. Education on restraints was provided again on 11/25/14 to the DON, ADON, UM, MDS Coordinator, SDC, and Rehabilitation Manager by the Regional Program Manager. Staff not working on 11/19/14 will receive education and testing prior to working. Signs were posted at the time clock. 20. All staff working 11/19/14 were interviewed by the Administrator, DON, HR Coordinator and SDC in regards to any resident having been restrained and the findings were negative. 21. A new policy for review of potential employees was put into place on 11/19/14, utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work. 22. The HR Director received disciplinary action from the Administrator and the HR Regional Services on 11/22/14. 23. Orientation for all new staff will include education on abuse, resident rights, cell phone policy, restraints, care plan and revision of the care plan. A post test would be administered with a passing score of 100%. 24. Education was provided by the facility department heads to the nursing staff on 11/26/14, upon notification of the care plan deficiency. A post test was provided regarding care plans and revisions and interim care plans, interventions that should have been added that are specific to the resident's care and care plan policies prior to reporting to their assignments. A post test with a required passing grade of 100% was required. If 100% accuracy was not obtained, staff members were to be re-educated and re-tested until 100% was obtained. Staff not on duty 11/26/14 were to receive education, prior to working their next shift. Licensed staff was to update care plans during their shift for any resident changes, concerns with behaviors, removing their assistive devices, new orders, or any concerns with the resident's care, and to incorporate goals and objectives that would lead to the resident's highest obtainable level of independence. The Administrator would be responsible for checking all audits for any concerns. If concerns were identified, the Administrator was to act immediately. The Administrator or Department Heads or the RN Week-end Supervisor will be on site daily to review all audits and tests to identify any concerns to ensure all abuse, neglect, misappropriation,

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) violation of resident rights, cell phone and restraint policies are being followed. A member of the regional staff or home office staff, Regional Nurse Special Projects, or Vice President of Operations were to have been on site daily until the immediacy was lifted and to ensure all audits and questionnaires were followed. If concerns were identified, the Administrator was to act immediately. 25. Walking rounds will be conducted two (2) times each eight (8) hour shift, for all residents, by the Department Managers to observe for abuse, neglect, misappropriation, violation of resident rights, cell phone and restraints, until the immediacy was lifted. During these rounds, two (2) staff members were to be tested regarding these issues and 100% accuracy was required or re-education was to have been administered. Also during the rounds, two (2) residents were to have been interviewed regarding any issues or concerns. Any violations of these policies was to have been addressed by ensuring the resident was safe, and reporting to the Charge Nurse, as well as the Administrator, per policy. Findings of all rounds and audits are to be reported to the DON and Administrator daily, who in turn are to report any concerns to the State Agencies and follow the abuse procedures and policies for reporting, protecting, etc. QA will review the results of all tests, interviews, and rounding observations to analyze results and determine if the frequency could have been reduced as well as any need for re-education. 26. The DON, ADON, or Staff Development Coordinator (SDC) will review the daily physician's orders [REDACTED]. 27. The IDT will hold daily meetings, beginning 11/26/14, in which a review of the twenty-four (24) hour nursing report for any changes of condition, any new admission, re-admission or concerns with the removal of assistive devices, as well as Physician Orders, for any changes or documentation requiring an interim care plan, a new care plan or a revision of the care plan. Care plans will be reviewed to ensure compliance, until the immediacy is lifted. Once the immediacy has been lifted, the IDT will continue to meet daily and ongoing for review of the care plans. 28. A QA meeting was conducted on 11/20/14, to discuss incidents as well as all education provided, assessments provided, assessments of all residents with devices, processes for restraints, employee files regarding any staff having been convicted of a felony and all reviewed with the Medical Director. 29. Weekly Quality Performance Improvement meetings with the Medical Director to be on-going. The meetings are to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings were to reviewed, trended and the committee would determine the course of action. **The State Survey Agency validated the corrective action taken by the facility on 12/04/14 as follows: 1. On 12/02/14, five (5) staff members' personnel files were reviewed: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4, regarding their written disciplinary actions, the restraint of Resident #4 and the failure to report abuse. The review also revealed on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. Review of the Resident #4's skin assessments, family and physician notification, care plan revision, ITP reviews of the seat-belt alarm restraint assessment, documentation and the physician order [REDACTED]. 3. Review of the Resident #4's care plan revisions, to include the use of the seat-belt, as a restraint device and alternate coping strategies when the resident became agitated, dated 11/19-26/14; consent for the use of restraints, dated 11/19/14; physician's orders [REDACTED]. 4. Review of the IDT Notes and Comprehensive Care Plan for At Risk for Harm/Injury, related to the seat belt, dated 11/19/14 and the Resident At Risk for and/or Expressing Anxiety Care Plan, dated 11/19/14 and interventions, dated 11/26/14, revealed the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. Review of the Social Services Progress Notes, dated 11/20/14-11/25/14, revealed the Social Service Director (SSD) assessed the resident daily for psychosocial harm and no concerns were identified. 6. Review of the Instructions for Walking Rounds and Audit Sheets, dated 11/19/14 through 12/01/14 revealed walking rounds were completed twice each eight (8) hour shift to identify if there were any restraints or potential restraints. No concerns were identified. 7. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with the Administrator and Director of Nursing (DON) at 12:45 PM, the HR Director at 3:35 PM and LPN #6 at 3:50 PM revealed they had been inserviced and were educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights, a post-test was administered, with a required 100 percent (%) pass rate and all stated they had been inserviced and passed the test, with a 100 % pass rate. 8. Interview with the HR Director, on 12/02/14 at 3:35 PM, revealed she had been educated on the new policy for review of potential employees, put into place on 11/19/14 and utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications that would be reviewed by the HR Director for eligibility. Further interview revealed the Administrator would complete the final review, before a potential employee would be allowed to work. 9. Review of the Audit Records, dated 11/19/14, revealed no concerns. Review of Personnel records revealed LPN #1 was terminated on 11/19/14, for falsification of the application for employment, regarding not having any felony on her records and review of the result of the audit for personnel records, back to 2003 and a review of the Policy for Criminal Background Checks, dated 11/19/14, revealed no other concerns were identified. 10. Review of the Instructions for Walking Rounds and the 100% Visual Audit Tool, dated 11/19-24/14, revealed all residents with any devices that could be categorized as a restraint, were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications. No concerns were identified. 100% audits of all resident's care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. A review of the 100% audits, dated 11/19-24/14, completed during walking rounds, revealed on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts, which were made and installed by the manufacturer of the electric wheel chair, had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents were reviewed or obtained, as evidenced by review of Resident #1's and Resident B's records. It was determined, per the Pre-Restraining Evaluation, dated 11/25/14, these were not restraints for these residents. 12. Review of Post Testing, dated 11/20-25/14, The Healthcare-In-Service Sign-In Sheets for Department Heads, dated 11/19/14, and interviews on 12/02/14 with the HRD at 3:35 PM, the ADON at 3:50 PM, and the Administrator and DON at 12:45 PM, revealed the Department Heads were educated on care plans, revision of the care plan and each nurse's role in regard to updating and implementing appropriate interventions. A post test requiring 100% pass rate was required. 13. Review of the 11/25-26/14 Census Board Audit Sheets revealed the IDT team made walking rounds, and completed them on all residents. Review of the IDT meeting notes, dated 11/25-26/14 revealed they met to discuss interventions related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Review of Care plans for Unsampled Residents B, C, D, E, and F, who required alarms, revealed they were reviewed and/or updated on 11/26/14 to include the new interventions. 14. Verified with the SSA Complaints Coordinator any concerns identified during the facility's resident interviews, were received on 12/01/14 and she was waiting on the final reports. Interviews conducted on 12/03/14 with Unsampled Resident B, at 9:25 AM; Resident C at 1:35 PM; Resident D, at 11:00 AM; Resident E, at 2:50 PM; and, Resident F, at 12:00 PM, revealed no concerns with resident care, abuse, neglect or any restraint activity. 15. Review of the Resident Council Minutes, dated 11/19/14, revealed the residents were educated on abuse, neglect, restraints and reporting these concern to staff and the DON and Administrator. 16. Review of five (5) residents with head-to-toe skin assessments, who were assessed to have a BIMS' score less than eight (8), revealed the assessments were completed by the ADON and UM, on 11/19/14. No concerns were identified. 17. Review of the family contacts for five (5) family members of residents, with a BIMS' score of less than eight (8) revealed they were completed on 11/20/14 by the BOM. No concerns were identified. Interview with a family member for Resident #4, on 11/21/14 at 2:30 PM, revealed no concerns. 18. Incident/Accident Reports dated 08/01/14 through 11/20/14 were reviewed related to abuse, neglect, inappropriate restraints or violation of resident rights. No concerns were identified. 19. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, and CNA #14 at 5:00 PM; and, on 12/04/14 with LPN #7 at 8:02 AM; CNA #15 at 7:45 AM and CNA #16, at 8:00 AM, revealed they were educated and tested on abuse and neglect, restraints, cell phones, and resident rights. 20. Review of the staff's written statements, dated 11/19/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and DON at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16, at 8:00 AM, revealed all were aware of the definition of restraints and abuse. 21. Review of the facility's general orientation policy utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work, was reviewed with no concerns. Review of the facility's policy for Pre-Hire Check List, dated 11/19/14, revealed it included a clause regarding the Administrator's final review before the potential employee is allowed to work. 22 Review of the written reprimand for the HRD on 11/22/14 and interview with the HRD, on 12/02/14 at 3:35 PM revealed she had training on the new policy and check list and the Administrator had

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 8) to sign-off on this, prior to anyone being hired. Interview with the Administrator, on 12/02/14 at 8:35 AM revealed they had a double check system now and there should be no other problems with screening of employees, prior to hiring. 23. A review of the Orientation Packet on 12/03/14, with policies to include: Abuse Prevention Policy and Procedure, dated April 2013; Health Insurance Portability and Accountability Act (HIPAA) Policy, undated; Resident Rights, undated; Restraint Reduction, dated 12/20/10; Social Media, dated 03/01/13; Care Planning, dated October 2013; Change in a Resident's Condition, dated October 2013; Goals and Objectives of the Care Plans, dated April 2011; Resident/ Family Participation in the Care Plan, dated December 2006; and Usage of the Care Plan, dated August 2006, revealed no concerns. 24. Review of auditing and testing records, dated 11/19/14 through 12/02/14, used to ensure all abuse, neglect, misappropriation, violation of resident rights, cell phone use and restraint policies were being followed, revealed no concerns. Care plan education and testing was provided to staff on 11/26/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and the DON on at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16 at 8:00 AM, revealed all were aware of the definition of restraints and abuse, when and to whom they were to report these things and all had education on the care plans. A review of pre-testing and post-tests administered 11/20-26/14, revealed no concerns. 25. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three (3) QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 26. Review of the audit sheets for Residents With Assistive Devices, Daily Clinical Meetings; Walking Rounds and Testing of Staff, dated 11/19/14 through 12/01/14, revealed no concerns. 27. Review of the daily IDT records for 11/26/14-12/01/14, audits for residents with any assistive devices, 24 Hour Reports Reviews, physician's orders [REDACTED]. 28. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 29. Interviews with the Administrator on 12/02/14 at 8:35 AM and the DON on 12/04/14 at 10:35 AM, revealed the weekly Quality Performance Improvement meetings with the Medical Director would be on-going and the meetings were to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings would be reviewed, trended and the committee would determine the course of action. Interviews with the DON on 12/02/14 at 8:35 AM; and, on 12/04/14 at 10:35 AM, revealed the IDT will continue an on-going weekly assessment to review all devices and restraints for the continued need, reduction attempt or elimination.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation, interview and review of the facility's policy it was determined the facility failed to ensure a safe, clean and comfortable environment related to observations on 11/18/14 of the 100, 200 and 300 Halls. Observation revealed multiple ceiling fans with a large build up of dust on all the fan blades. The findings include: Interview with the Administrator, on 11/20/14 at 3:45 PM, revealed there was no specific policy and procedure related to cleaning of the facility's ceiling fans. Additionally, the ceiling fans were not addressed on the itemized cleaning list. However, the Administrator stated his expectation was that the ceiling fans were to kept in a clean condition. Observations during the initial tour, on 11/18/14 at 12:35 PM, revealed there were five (5) ceiling fans with a build up of gray dust on all blades on each of the three (3) halls (100, 200 and 300 halls). Interview with the Housekeeping Supervisor, on 11/18/14 at 1:30 PM, revealed she was unaware of who was responsible for ensuring the fan blades were kept clean. During further interview at 1:45 PM, with the Housekeeping Supervisor she stated she had been employed in housekeeping for three (3) months and had not cleaned the fan blades since she had been at the facility. Observation and interview with the Assistant Director of Nursing (ADON), on 11/18/14 at 2:00 PM, revealed the fan blades were very dirty and they were an infection control issue. She stated she did not know if there was a schedule for housekeeping to maintain the cleanliness of the fan blades. Interview with the Administrator, on 11/18/14 at 2:30 PM, revealed he expected the ceiling fans in the facility to be kept clean.
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 interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to revise the Interim Care Plan for one (1) of fifteen (15) sampled residents (Resident #4). Resident #4 had behaviors of releasing his/her self-releasing alarming seatbelt causing the alarm to repeatedly sound; however, review of the Interim Care Plan revealed there were no interventions to address what staff should do when the resident had this behavior. On 11/19/14, Certified Nursing Assistant (CNA) #1 and CNA #3 observed Resident #4 on the hallway in his/her wheelchair with a blanket/sheet over the seatbelt around the resident and secured to the back of the wheelchair. CNA #2 stated the resident was continuously causing the seatbelt to alarm so she placed the blanket around the resident. (Refer to F221) The facility's failure to revise the Interim Care Plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/21/14 and determined to exist on 11/19/14. The facility was notified of the Immediate Jeopardy on 11/21/14. An acceptable Allegation of Compliance (AoC) was received on 12/01/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 11/27/14, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC); and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy and procedures titled, Care Planning, last revised 08/2014, revealed A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission. The preliminary care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan. Goals and objectives are reviewed and or/revised when the desired outcome has not been achieved and the Nurse Supervisor will use the care plan to complete the CNA's daily/weekly work assignment sheets and/or flow sheet. Record review revealed the facility admitted Resident #4 on 11/05/14 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) Assessment, dated 11/12/14, revealed the facility assessed Resident #4's cognition as severely impaired, with a Brief Interview of Mental Status (BIMS) score of 2 indicating the resident was non-interviewable. Review of the Pre-Restraining Evaluation, dated 11/12/14, revealed the resident was assessed for the use of an alarming self-release seatbelt due to chair alarms not preventing falls. The resident was able to self-release the seatbelt. Review of the Interim Care Plan for Falls, dated 11/09/14, revealed the resident was at risk for falls related to a previous fall. Review of the Interim Care Plan for Activities, dated 11/12/14, revealed an intervention was put in place on 11/12/14 to use an alarming seatbelt for safety and to alert staff with self transfers; however, there were no interventions to address the resident's behavior of continuously removing the seatbelt. Review of Nursing Notes, dated 11/13/14 and 11/16/14 (no times), and interviews with CNA #11, CNA #3, CNA #9, and Licensed Practical Nurse (LPN) #5 revealed the resident would repeatedly release the seatbelt and cause the alarm to sound. However, further review of the Interim Care Plan revealed the care plan was not revised to include interventions to address the resident's behavior of repeatedly releasing the seatbelt and causing it to alarm. Interviews with and review of witness statements of CNA #1 and CNA #3, revealed on 11/19/14, CNA #1 and CNA #3 witnessed Resident #4 on the hall in his/her wheelchair with a self-releasing seat belt and clip alarm on his/her person. There was a blanket/sheet wrapped around the resident's waist and secured to the back of the resident's wheelchair. Interview with CNA #2, on 11/26/14 at 12:51 PM, revealed she did not try anything else before putting the blanket over the seat belt and she thought covering the belt was okay. She stated she just tried to cope with Resident #4 the best way she could and it was hard to come up with ideas to keep the resident distracted so the resident would leave the seatbelt alone so she could provide care for other residents. CNA #2 stated she was trying to keep Resident #4 from getting up out of his/her wheel chair and falling. Interview with CNA #11, on 11/20/14 at 6:30 PM, revealed she had to roll Resident #4 around as she provided care to other residents, so she could catch the resident before she/he tried to release the safety belt and get up out of his/her wheelchair. Interview with CNA #3, on 11/26/14 at 12:11 PM, revealed she tried to keep the resident occupied by giving him/her things to do during the night, but that was really hard to do when she were trying to provide care for other residents. She stated she just tried things that popped in her mind to distract the resident from the seatbelt, but

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	185195	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKVIEW NURSING & REHABILITATION CENTER	10456 US HWY 62 CALVERT CITY, KY 42029

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) there was nothing ever in writing for her to try to distract the resident. Interview with CNA #9, on 11/20/14 at 6:05 PM, revealed he just tried to keep Resident #4 in his view and was not really sure how to keep him/her occupied. Interview with LPN #5 on 11/26/14 at 11:26 AM, revealed she had attempted to redirect Resident #4 by having the resident fold wash cloths, offering him/her a snack, reading him/her the newspaper, keeping the resident in her view at all times and talking one on one with the resident. She further stated, these diversions were just something she had come up with over her years as a experienced nurse working with the elderly. She revealed these interventions were not added to Resident #4's care plan for the CNAs to try with Resident #4 but the interventions should have been added to the Interim Care Plan so the CNAs and any staff providing care to the resident would have known what interventions to try when the resident was removing his/her seatbelt. Interview with Minimum Data Set (MDS) Coordinator, on 11/26/14 at 11:30 AM, revealed the floor nurses were responsible for developing and updating the interim care plans until the Comprehensive Care Plan was developed. Interview with the DON on 11/26/14 at 2:10 PM, revealed she would have expected any and all licensed nursing staff to update and revise the Interim Care Plan as needed to reflect new interventions needed for Resident #4 until the Comprehensive Care Plan was developed. If this had been done, all staff providing care to the resident would have known interventions to keep Resident #4 from releasing his/her self-releasing seat belt. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 11/19/14, the facility suspended five (5) staff members: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4; and, on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. On 11/19/14, the Unit Manager (UM) assessed Resident #4 for any signs of injury and none were observed. The family and the physician were notified of the allegation on 11/19/14 by the ADON and initial reports were filed with the (State Survey Agency) SSA on 11/19/14 by the Administrator. 3. The Interdisciplinary Team (IDT) reassessed Resident #4 for the self-releasing seat belt and this was deemed to have been a restraint for this resident, due to the resident not being able to release the restraint on command. The family and physician were notified on 11/19/14, a consent form and a physician's orders [REDACTED]. 4. On 11/26/14, the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. The Social Services Director (SSD) assessed the resident for psychosocial harm and none was identified on 11/20/14-11/25/14. 6. Walking rounds were made twice each eight (8) hour shift to visually assess each resident for any restraint or potential restraint not previously assessed, or ordered by the physician and no concerns were identified. 7. All department heads (Administrator, DON, ADON, Unit Manager, Staff Development Coordinator {SDC}, SSD, Chaplain, Business Office Manager {BOM}, Dietary Manager, Rehabilitation Manager, MDS Coordinator, Quality of Life Director, and Human Resource Director {HRD}were educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights. A post-test was administered, with a required 100 percent (%) pass rate. 8. The HR Director was re-educated by the Chief Nurse Executive regarding back-ground checks and following the facility policy on 11/19/14. 9. On 11/19/14, the Regional HR Services performed 100% audit of criminal background results of all active employees from 04/2013 to present with no concerns noted. 10. All residents with any devices that could be categorized as a restraint were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications and none were identified. Care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. During walking rounds and audits it was discovered on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents have been reviewed or obtained. 12. On 11/26/14, education was provided to the Department Head Team by the Chief Nurse Executive regarding care plans, revision of the care plan and the role each nurse has in regard to updating and implementing appropriate interventions and a post test requiring 100% pass rate was required. 13. On 11/26/14, the IDT team made walking rounds on all residents and met to discuss interventions as it related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Care plans were reviewed and/or updated on 11/26/14 to include the new interventions if applicable. 14. Residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater were interviewed on 11/19/14, by the Administrator, DON, ADON, Chaplain and SSD regarding concerns with care or possible restraint activity and all concerns, most of which were concerning missing items, were reported to the SA. 15. A Resident Council Meeting was held on 11/19/14, to discuss abuse, neglect and resident rights. This meeting was reviewed by the Administrator for any concerns. 16. Head-to-toe skin assessments were conducted 11/19-20/14 by the ADON and UM for residents with a BIMS' score less than eight (8) with no concerns identified. 17. Interviews were conducted with family members of residents with a BIMS' score of less than eight (8) on 11/20/14 by the BOM, with no concerns identified. 18. Incident/Accident Reports for 08/01/14 through 11/20/14 were reviewed by the Nurse Consultant related to abuse, neglect, inappropriate restraints or violation of resident rights and no concerns were identified. 19. The Staff Development Coordinator provided education on abuse and neglect, restraints, cell phones, and resident rights to all staff working 11/19/14 and a post test, with a required 100 percent (%) pass rate was administered. Education on restraints was provided again on 11/25/14 to the DON, ADON, UM, MDS Coordinator, SDC, and Rehabilitation Manager by the Regional Program Manager. Staff not working on 11/19/14 will receive education and testing prior to working. Signs were posted at the time clock. 20. All staff working 11/19/14 were interviewed by the Administrator, DON, HR Coordinator and SDC in regards to any resident having been restrained and the findings were negative. 21. A new policy for review of potential employees was put into place on 11/19/14, utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work. 22. The HR Director received disciplinary action from the Administrator and the HR Regional Services on 11/22/14. 23. Orientation for all new staff will include education on abuse, resident rights, cell phone policy, restraints, care plan and revision of the care plan. A post test would be administered with a passing score of 100%. 24. Education was provided by the facility department heads to the nursing staff on 11/26/14, upon notification of the care plan deficiency. A post test was provided regarding care plans and revisions and interim care plans, interventions that should have been added that are specific to the resident's care and care plan policies prior to reporting to their assignments. A post test with a required passing grade of 100% was required. If 100% accuracy was not obtained, staff members were to be re-educated and re-tested until 100% was obtained. Staff not on duty 11/26/14 were to receive education, prior to working their next shift. Licensed staff was to update care plans during their shift for any resident changes, concerns with behaviors, removing their assistive devices, new orders, or any concerns with the resident's care, and to incorporate goals and objectives that would lead to the resident's highest obtainable level of independence. The Administrator would be responsible for checking all audits for any concerns. If concerns were identified, the Administrator was to act immediately. The Administrator or Department Heads or the RN Week-end Supervisor will be on site daily to review all audits and tests to identify any concerns to ensure all abuse, neglect, misappropriation, violation of resident rights, cell phone and restraint policies are being followed. A member of the regional staff or home office staff, Regional Nurse Special Projects, or Vice President of Operations were to have been on site daily until the immediacy was lifted and to ensure all audits and questionnaires were followed. If concerns were identified, the Administrator was to act immediately. 25. Walking rounds will be conducted two (2) times each eight (8) hour shift, for all residents, by the Department Managers to observe for abuse, neglect, misappropriation, violation of resident rights, cell phone and restraints, until the immediacy was lifted. During these rounds, two (2) staff members were to be tested regarding these issues and 100% accuracy was required or re-education was to have been administered. Also during the rounds, two (2) residents were to have been interviewed regarding any issues or concerns. Any violations of these policies was to have been addressed by ensuring the resident was safe, and reporting to the Charge Nurse, as well as the Administrator, per policy. Findings of all rounds and audits are to be reported to the DON and Administrator daily, who in turn are to report any concerns to the State Agencies and follow the abuse procedures and policies for reporting, protecting, etc. QA will review the results of all tests, interviews, and rounding observations to analyze results and determine if the frequency could have been reduced as well as any need for re-education. 26. The DON, ADON, or Staff Development Coordinator (SDC) will review the daily physician's orders [REDACTED]. 27. The IDT will hold daily meetings, beginning 11/26/14, in which a review of the twenty-four (24) hour nursing report for any changes of condition, any new admission, re-admission or concerns with the removal of assistive devices, as well as Physician Orders, for any changes or documentation requiring an interim care plan, a new care plan or a revision of the care plan. Care plans will be reviewed to ensure compliance, until the immediacy is lifted. Once the immediacy has been lifted, the IDT will continue to meet daily and ongoing for review of the care plans. 28. A QA meeting was conducted on 11/20/14, to discuss incidents as well as

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) all education provided, assessments provided, assessments of all residents with devices, processes for restraints, employee files regarding any staff having been convicted of a felony and all reviewed with the Medical Director. 29. Weekly Quality Performance Improvement meetings with the Medical Director to be on-going. The meetings are to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings were to reviewed, trended and the committee would determine the course of action. **The State Survey Agency validated the corrective action taken by the facility on 12/04/14 as follows: 1. On 12/02/14, five (5) staff members' personnel files were reviewed: CNA #1, CNA #2, CNA #3, LPN #2 and LPN #4, regarding their written disciplinary actions, the restraint of Resident #4 and the failure to report abuse. The review also revealed on 11/23/14, CNA #1, CNA #3 and LPN #4 were terminated. 2. Review of the Resident #4's skin assessments, family and physician notification, care plan revision, ITP reviews of the seat-belt alarm restraint assessment, documentation and the physician order [REDACTED]. 3. Review of the Resident #4's care plan revisions, to include the use of the seat-belt, as a restraint device and alternate coping strategies when the resident became agitated, dated 11/19-26/14; consent for the use of restraints, dated 11/19/14; physician's orders [REDACTED]. 4. Review of the IDT Notes and Comprehensive Care Plan for At Risk for Harm/Injury, related to the seat belt, dated 11/19/14 and the Resident At Risk for and/or Expressing Anxiety Care Plan, dated 11/19/14 and interventions, dated 11/26/14, revealed the IDT met and discussed Resident #4's actions of un-securing the alarming seatbelt and attempts to self transfer. The care plan was reviewed and updated to include specific interventions for staff to utilize while providing care for the resident. 5. Review of the Social Services Progress Notes, dated 11/20/14-11/25/14, revealed the Social Service Director (SSD) assessed the resident daily for psychosocial harm and no concerns were identified. 6. Review of the Instructions for Walking Rounds and Audit Sheets, dated 11/19/14 through 12/01/14 revealed walking rounds were completed twice each eight (8) hour shift to identify if there were any restraints or potential restraints. No concerns were identified. 7. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with the Administrator and Director of Nursing (DON) at 12:45 PM, the HR Director at 3:35 PM and LPN #6 at 3:50 PM revealed they had been inserviced and were educated by the Regional Nurse Consultant on 11/19/14 regarding abuse, neglect, restraints, the cell phone policy and resident rights, a post-test was administered, with a required 100 percent (%) pass rate and all stated they had been inserviced and passed the test, with a 100 % pass rate. 8. Interview with the HR Director, on 12/02/14 at 3:35 PM, revealed she had been educated on the new policy for review of potential employees, put into place on 11/19/14 and utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications that would be reviewed by the HR Director for eligibility. Further interview revealed the Administrator would complete the final review, before a potential employee would be allowed to work. 9. Review of the Audit Records, dated 11/19/14, revealed no concerns. Review of Personnel records revealed LPN #1 was terminated on 11/19/14, for falsification of the application for employment, regarding not having any felony on her records and review of the result of the audit for personnel records, back to 2003 and a review of the Policy for Criminal Background Checks, dated 11/19/14, revealed no other concerns were identified. 10. Review of the Instructions for Walking Rounds and the 100% Visual Audit Tool, dated 11/19-24/14, revealed all residents with any devices that could be categorized as a restraint, were assessed by administrative nursing (DON, ADON, UM, MDS Coordinator, and SDC) to determine appropriateness, based on medical symptoms and correct applications. No concerns were identified. 100% audits of all resident's care plans were reviewed to reflect current status. Orders and consents were reviewed or obtained based upon the reassessment. No other devices were assessed as restraints. 11. A review of the 100% audits, dated 11/19-24/14, completed during walking rounds, revealed on 11/25/14 that two (2) residents with electric wheelchairs with seatbelts, which were made and installed by the manufacturer of the electric wheel chair, had not been assessed. The residents were assessed by the IDT team on 11/25/14 and care plans, orders and consents were reviewed or obtained, as evidenced by review of Resident #1's and Resident B's records. It was determined, per the Pre-Restraining Evaluation, dated 11/25/14, these were not restraints for these residents. 12. Review of Post Testing, dated 11/20-25/14, The Healthcare-In-Service Sign-In Sheets for Department Heads, dated 11/19/14, and interviews on 12/02/14 with the HRD at 3:35 PM, the ADON at 3:50 PM, and the Administrator and DON at 12:45 PM, revealed the Department Heads were educated on care plans, revision of the care plan and each nurse's role in regard to updating and implementing appropriate interventions. A post test requiring 100% pass rate was required. 13. Review of the 11/25-26/14 Census Board Audit Sheets revealed the IDT team made walking rounds, and completed them on all residents. Review of the IDT meeting notes, dated 11/25-26/14 revealed they met to discuss interventions related to residents who required alarms, due to history of behaviors of self transfer attempts and seatbelts. Review of Care plans for Unsampled Residents B, C, D, E, and F, who required alarms, revealed they were reviewed and/or updated on 11/26/14 to include the new interventions. 14. Verified with the SSA Complaints Coordinator any concerns identified during the facility's resident interviews, were received on 12/01/14 and she was waiting on the final reports. Interviews conducted on 12/03/14 with Unsampled Resident B, at 9:25 AM; Resident C at 1:35 PM; Resident D, at 11:00 AM; Resident E, at 2:50 PM; and, Resident F, at 12:00 PM, revealed no concerns with resident care, abuse, neglect or any restraint activity. 15. Review of the Resident Council Minutes, dated 11/19/14, revealed the residents were educated on abuse, neglect, restraints and reporting these concern to staff and the DON and Administrator. 16. Review of five (5) residents with head-to-toe skin assessments, who were assessed to have a BIMS' score less than eight (8), revealed the assessments were completed by the ADON and UM, on 11/19/14. No concerns were identified. 17. Review of the family contacts for five (5) family members of residents, with a BIMS' score of less than eight (8) revealed they were completed on 11/20/14 by the BOM. No concerns were identified. Interview with a family member for Resident #4, on 11/21/14 at 2:30 PM, revealed no concerns. 18. Incident/Accident Reports dated 08/01/14 through 11/20/14 were reviewed related to abuse, neglect, inappropriate restraints or violation of resident rights. No concerns were identified. 19. Review of the POS [REDACTED]. Interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, and CNA #14 at 5:00 PM; and, on 12/04/14 with LPN #7 at 8:02 AM; CNA #15 at 7:45 AM and CNA #16, at 8:00 AM, revealed they were educated and tested on abuse and neglect, restraints, cell phones, and resident rights. 20. Review of the staff's written statements, dated 11/19/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and DON at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16, at 8:00 AM, revealed all were aware of the definition of restraints and abuse. 21. Review of the facility's general orientation policy utilizing a pre-hire check list, in which all employees' criminal background checks, abuse registry checks and license verifications would be reviewed by the HR Director for eligibility. The Administrator would complete the final review, before a potential employee would be allowed to work, was reviewed with no concerns. Review of the facility's policy for Pre-Hire Check List, dated 11/19/14, revealed it included a clause regarding the Administrator's final review before the potential employee is allowed to work. 22 Review of the written reprimand for the HRD on 11/22/14 and interview with the HRD, on 12/02/14 at 3:35 PM revealed she had training on the new policy and check list and the Administrator had to sign-off on this, prior to anyone being hired. Interview with the Administrator, on 12/02/14 at 8:35 AM revealed they had a double check system now and there should be no other problems with screening of employees, prior to hiring. 23. A review of the Orientation Packet on 12/03/14, with policies to include: Abuse Prevention Policy and Procedure, dated April 2013; Health Insurance Portability and Accountability Act (HIPAA) Policy, undated; Resident Rights, undated; Restraint Reduction, dated 12/20/10; Social Media, dated 03/01/13; Care Planning, dated October 2013; Change in a Resident's Condition, dated October 2013; Goals and Objectives of the Care Plans, dated April 2011; Resident/ Family Participation in the Care Plan, dated December 2006; and Usage of the Care Plan, dated August 2006, revealed no concerns. 24. Review of auditing and testing records, dated 11/19/14 through 12/02/14, used to ensure all abuse, neglect, misappropriation, violation of resident rights, cell phone use and restraint policies were being followed, revealed no concerns. Care plan education and testing was provided to staff on 11/26/14 and interviews conducted on 12/02/14 with RN #1 at 3:18 PM, RN #2 at 4:30 PM, LPN #6 at 3:50 PM, CNA #13 at 3:25 PM, CNA #14 at 5:00 PM, the HRD at 3:35 PM, the ADON at 3:50 PM and the Administrator and the DON on at 12:45 PM; and, on 12/04/14 with LPN #7 at 8:02 AM, CNA #15 at 7:45 AM, and CNA #16 at 8:00 AM, revealed all were aware of the definition of restraints and abuse, when and to whom they were to report these things and all had education on the care plans. A review of pre-testing and post-tests administered 11/20-26/14, revealed no concerns. 25. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three (3) QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 26. Review of the audit sheets for Residents With Assistive Devices, Daily Clinical Meetings; Walking Rounds and Testing of Staff, dated 11/19/14 through 12/01/14, revealed no concerns. 27. Review of the daily IDT records for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185195	A. BUILDING _____ B. WING _____	**12/04/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKVIEW NURSING & REHABILITATION CENTER	**10456 US HWY 62 CALVERT CITY, KY 42029**

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 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) 11/26/14-12/01/14, audits for residents with any assistive devices, 24 Hour Reports Reviews, physician's orders [REDACTED]. 28. Interview with the Administrator and DON on 12/04/14 at 10:35 AM, revealed all concerns were documented and the facility had three QA Meetings with the Medical Director (11/19/14, 11/25/14 and 12/02/14) regarding the results of the testing, training, interviews, rounding and audits to analyze the results and determine any further training needs or further evaluation. 29. Interviews with the Administrator on 12/02/14 at 8:35 AM and the DON on 12/04/14 at 10:35 AM, revealed the weekly Quality Performance Improvement meetings with the Medical Director would be on-going and the meetings were to review the findings of on-going audits, tests, questions, education, new employee files and back ground checks and/or any new concerns identified. Findings would be reviewed, trended and the committee would determine the course of action. Interviews with the DON on 12/02/14 at 8:35 AM; and, on 12/04/14 at 10:35 AM, revealed the IDT will continue an on-going weekly assessment to review all devices and restraints for the continued need, reduction attempt or elimination.
F 0372 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Dispose of garbage and refuse properly.** Based on observation, interview and policy review, it was determined the facility failed to ensure proper disposal of garbage. The facility failed to maintain closed doors on the dumpsters; failed to ensure the dumpsters were kept on a washable surface; and, failed to maintain the site around the dumpsters. The findings include: Review of the facility's policy, Cleaning and Maintaining Around the Dumpsters, undated, revealed the Dietary and Maintenance Departments were responsible to maintain the area around the dumpsters twice daily (once in the morning and the afternoon) to keep the area clean and ensure the doors to the dumpster were closed after use. Observation of the three (3) dumpsters, on 11/19/14 at 11:07 AM, revealed one (1) of the dumpsters was three (3) to six (6) feet off the cement pad, in the mud; and the other two (2) dumpsters were one (1) to two (2) feet off the pad. Further observation revealed two (2) doors were open on one (1) of the dumpsters. Observations, during the tour revealed there were numerous paper products, plastic bags and gloves, some in a darkened state of disintegration, as if having been there a while, out on the ground along the back and side of the dumpsters Interview with the Dietary Manager, on 11/19/14 at 11:15 AM, revealed she was sure it was everyone's responsibility to check the dumpster area, whenever trash was taken out and ensure the doors were closed. She stated she was not sure who should have ensured the trash was off the ground. She stated the refuse collector had always had a problem getting the dumpsters back on the pad properly. Interview with the Administrator, on 11/21/14 at 4:00 PM, revealed he was not aware of the problem but would ensure it would be rectified.