STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185180		**04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's Abuse Policy and investigation, it was determined the facility failed to ensure each resident was free from abuse for one of twelve (12) sampled residents (Resident #2). On 03/02/16, during the evening meal, Certified Nursing Assistants (CNA) #2 and #3 observed CNA #4 strike Resident #2 twice on the forearm. CNA #4 admitted to swatting the resident's forearm when the resident attempted to grab at a food tray. The facility failed to have an effective system in place to ensure residents were free from abuse placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) was identified on 03/18/16 and determined to exist on 03/02/16. The facility was notified of the IJ on 03/18/16. An acceptable Allegation of Compliance (AOC) was received on 03/22/16 and the State Survey Agency (SSA) validated the IJ was removed on 03/19/16, as alleged. The Scope and Severity (S/S) was lowered to a D while the facility developed and implemented the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitored the effectiveness of the systemic changes. The findings include: Review of the facility's Abuse and Neglect Policy, revised March 2013, revealed verbal, sexual, physical, and mental abuse, corporate punishment, neglect involuntary seclusion of the resident, resident exploitation as well as misappropriation of resident property were prohibited. Review of the facility's investigation, dated 03/08/16, revealed CNA #2 reported to Registered Nurse (RN) #1, on 03/07/16 at 7:15 PM, that she had observed CNA #4 smack Resident #2 on the arm last week. The Administrator and the Assistant Director of Nursing (ADON) were notified. The Administrator directed RN #1 to interview CNA #4 and then suspend the aide. RN #1 documented that CNA #4 admitted to swatting the resident's forearm when the resident attempted to grab at a food tray. The investigative report stated there were two (2) aides that had witnessed the abuse; however, they had not reported the abuse. All three (3) aides were suspended on 03/07/16. Review of the final report, dated 03/11/16, revealed the facility substantiated the allegation of abuse when CNA #4 admitted to hitting the resident on the forearm. The facility's investigation revealed the two (2) aides that had witnessed the abuse (on 03/02/06 during the evening meal) had not reported the abuse. The facility notified the state agencies on 03/08/16. The facility began education on their Abuse Policy on 03/08/16. Record review revealed Resident #2 had resided at the facility since July 2009. Review of the most current [DIAGNOSES REDACTED]. Record review revealed the facility had assessed the resident to have a severe cognition loss and was unable to conduct a Brief Interview of Mental Status (BIMS) test. Review of the most recent Minimum Data Set (MDS) assessment, conducted on 02/22/16, revealed the resident required extensive assistance with eating. Review of the comprehensive care plan for the problem of communication, dated 02/22/16, revealed the Resident #2's communication was impaired and the resident was unable to understand or be understood. The goal was for the resident's needs to be anticipated by staff. A new intervention was added on 03/07/16 to place the resident's food tray out of reach of the resident. Interview with CNA #3, on 03/15/16, at 4:57 PM, revealed he observed CNA #4 slap Resident #2's forearm in the dining room on 03/02/16. He stated CNA #4 was assisting Resident #2 with the evening meal when the resident reached for the food tray. He stated the resident had a history of [REDACTED]. When the resident reached for the food tray, CNA #4 slapped the resident on the forearm and slapped the resident again when he/she reached for the food tray. This time the resident said, Ouch. CNA #3 told the aide he did not want to do that, but CNA #4 told him it was okay. CNA #3 told the aide it was not okay. He stated License Practical Nurse (LPN) #5 was in the dining room at that time and told him she would take care of it and he thought the nurse had reported the abuse. However, he did not see her speak with CNA #4 that night and the aide continued to care for residents. Further interview revealed CNA #2 came to him several nights later (03/07/16) and said he needed to speak with RN #1 about what they had observed in the dining room. He stated there was a miscommunication and he didn't realize the alleged abuse had not been reported. He assumed that LPN #5 had reported the abuse. A telephone interview with CNA #2, on 03/17/16 at 9:15 AM, revealed she had observed CNA #4 slap Resident #2 on the forearm twice on 03/02/16. She stated she did not report the allegation of abuse because a nurse was in the dining room at the same time of her observation and she assumed the nurse reported the abuse. She stated the resident was grabbing for the food tray and CNA #4 smacked the resident on the forearm with an opened hand. When the resident reached for the food tray again and CNA #4 smacked the resident again on the forearm. However, this time the resident said,Ouch, and began rubbing his/her arm. The CNA stated she knew this was wrong but since the nurse was in the dining room, she assumed she saw the same thing and would report the incident. When she saw CNA #4 working on 03/07/16 caring for residents, she realized the alleged abuse had not been reported. She stated she was uncomfortable with CNA #4 working with residents after what she observed and she was afraid he would hit another resident in private. She then reported what she observed to a staff nurse. A telephone interview with LPN #5, on 03/16/16 at 8:49 PM, revealed the nurse did not observe the alleged abuse and had not reported any abuse. The nurse stated she was not in the dining room for the whole meal and she did not witness the alleged abuse. LPN #5 stated she was new to the facility and was still in the learning mode. She stated nobody came to her that night and reported the alleged abuse. Telephone interview with CNA #4, on 03/16/16 at 8:26 PM, revealed he denied hitting the resident; he stated he pushed the resident's hand away. The aide stated the resident almost pulled the food tray onto the floor so he held the resident's hand. However, he then stated he touched the resident's arm. He stated he told the resident, No, No, while he was holding the resident's hand. The aide stated he continued to assist the resident with his/her meal and then transported the resident to the sunroom. He stated he continued to work with residents throughout the evening on 03/02/16. The aide validated he worked on March 3, 5, 6, and 7, 2016 after the incident in the dining room, and continued to care for Resident #2. Review of the work schedule and time sheet for CNA #4 revealed the aide worked on March 2, 3, 5, 6, and 7, 2016 caring for residents. On 03/07/16, the aide stated a nurse came to him and told him he was suspended and had to go home. He said the Administrator called him a few days later and told him he was terminated. Interview with the Administrator and the current Director of Nursing (DON) #3, on 03/16/16 at 9:12 AM, revealed the alleged physical abuse was reported to them on 03/07/16 after CNA #2 reported the abuse to a nurse. Upon knowledge of the alleged abuse, CNA #4 was suspended on 03/07/16. The Administrator stated CNA #2 and #3 were also suspended for not reporting the alleged abuse. According to the Administrator, when CNA #4 was interviewed, he admitted to smacking the resident's forearm twice. She terminated the aide because he (the aide) could not understand what he did was wrong and she was not sure the

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) aide would not slap another resident again. She substantiated the allegation and the facility's investigation found the two (2) aides failed to report the alleged abuse to the nurse according to facility policy. The Administrator further stated there were no changes made to the Abuse Policy and training of staff began on 03/08/16 and was ongoing. Additional interview with the Administrator and DON #3, on 03/17/16 at 4:25 PM, revealed the facility had not implemented any monitoring processes to ensure the training provided to staff was effective. DON #3 stated she had planned a staff meeting for 03/21/16 to go over the Abuse Policy and develop audits to ensure staff understood how to report abuse. However, they had not implemented the processes yet. The Administrator stated she was waiting to have a Quality Assurance (QA) meeting scheduled for 03/24/16 after the monitoring audits were developed and implemented. The Administrator further stated she was ensuring compliance through the complaint/grievance process. The facility implemented the following actions to remove the Immediate Jeopardy: 1. The allegation of abuse against Resident #2 was reported to the State Agencies on 03/08/16. The facility's initial investigation was initiated on 03/07/16 by the Administrator, DON #2, and RN Nurse Manager. The facility suspended CNAs #2, #3, and #4 on 03/07/16. 2. The RN Unit Manager performed a skin assessment for Resident #2, on 03/07/16 and found no signs of abuse. On 03/10/16, skin assessments were conducted on those residents with a BIMS score of less than eight (8). No evidence of abuse was identified for any of those residents. 3. The facility (Social Services) interviewed residents with a BIMS scores of eight (8) and above utilizing the Investigation Questions for Resident Interview, beginning on 03/08/16. 4. The Administrator notified local law enforcement of the alleged abuse on 03/07/16. In addition, on 03/07/16 the RN Unit Manager notified Resident #2's Physician and Responsible Party of the alleged abuse. 5. The facility's Abuse Policy was reviewed by DON #3, Corporate Nurse Consultant and via telephone with the Medical Director on 03/07/16 and the Interdisciplinary Team on 03/18/16, with no revision required. 6. The Social Service Director assessed Resident #2 for possible psychosocial issues. No negative outcome was noted. 7. Resident #2's care plan was reviewed and revised on 03/07/16 by the RN Unit Manager. The care plan was revised to reflect a new order for Geri Sleeves to be applied to the resident's bilateral arms to prevent the resident from scratching his/her arms. 8. All staff received training on the Abuse Policy with a post test. Staff had to score 100% or retake the test. One hundred forty-one (141) out of one hundred sixty (160) employees received the training with the post test. Those who had not received the training were sent the training material with the post test via certified mail on 03/14/16. Employees will not be allowed to work until they had received the training and taken the post test. The Staff Development Nurse will provide abuse training during the orientation program for all new employees. 9. Beginning 03/18/16, DON #3 and the Unit Managers would conduct random skin checks for residents with a BIMS score less than eight (8) and Social Services would conduct interviews with residents with a BIMS' score greater than eight (8). The audits would be 10% of daily census for each group and conducted daily for two (2) weeks to ensure residents were free from abuse. The audits would decrease to 5% for five (5) days a week for two (2) weeks, then 5% three (3) times a week for one month. Staff interviews with a post test validation began on 03/18/16 where 10% of staff daily were given the abuse post test to ensure ongoing knowledge of various types of abuse and when and whom to report allegations of abuse. 10. An Ad Hoc QA meeting was conducted on 03/18/16 with the Medical Director via phone conference. The survey findings and AOC corrective plan were reviewed. The IDT team would meet weekly for four (4) weeks to review the audit findings until compliance is achieved. The SSA validated removal of the IJ on 03/19/16 as follows: 1. Review of the facility's investigation revealed the abuse investigation was initiated on 03/07/16 and the faxed report was sent to the Office of Inspector General (OIG) on 03/08/16 at 11:37 AM. Review of the Stakeholder Suspension Form, dated 03/17/16, revealed CNAs #2, #3, and #4 were suspended. CNA #2 and #3 received a counseling session on 03/09/16 for failure to follow the facility's policy and would be re-educated on the Abuse Policy. Interview with CNA #2, on 03/17/16 at 9:15 AM, revealed she had been suspended for not reporting the abuse. Interview with CNA #3, on 03/15/16, at 4:57 PM, revealed he had been suspended for not reporting the abuse. A telephone interview with CNA #4, on 03/16/16 at 8:26 PM, revealed he had been suspended on 03/07/16 and a few days later the Administrator had called and informed him he had been terminated. 2. Review of Resident #2's clinical record revealed a skin assessment was performed by the East Unit Manager, on 03/07/16 at 10:30 PM, with no bruises, only scratches noted to the underside of the resident's forearms, between the wrist and elbow. The resident's physician was notified of the scratches by the RN Unit Manager on 03/07/16 with an order for [REDACTED].>Interview with the RN Manager (now DON #3), on 03/15/16 at 9:10 AM, revealed she had called the resident's physician and obtained the order for the Geri Sleeves. Review of the AOC book revealed fifty-seven (57) skin assessments were conducted by the DON, Unit Managers and RN Charge Nurse on 03/10/16 with no evidence of abuse found. 3. Review of the resident's interviews revealed sixty-seven (67) residents were interviewed by Social Services beginning 03/08/16 with no concerns of abuse or mistreatment expressed. Interview with sampled Resident #1, on 03/16/16 at 8:25 AM, Resident #6 on 03/15/16 at 3:28 PM, Resident #7 on 03/16/16 at 10:02 AM, and Resident #9 on 03/28/16 at 9:37 AM, revealed the residents had not experienced any abuse and had not observed any abuse toward other residents. 4. Review of documentation with the local police contact information revealed the police were at the facility on 03/07/16. Interview with the Administrator and DON #3, on 03/16/16 at 9:12 AM, revealed local law enforcement was called and responded to the facility and tried to interview the resident. No charges were filed. DON #3 stated she had notified the resident's Responsible Party that night. On 03/07/16 DON #3 notified the Medical Director, who was on call as the resident's Primary Physician of the alleged abuse. 5. Review of the facility's Abuse Policy, dated March 2013, revealed no revisions were made. Interview with the Administrator, on 03/16/16 at 9:12 AM, revealed there had been no changes to the Abuse Policy. 6. Review of the Social Service Progress Note, dated 03/08/16 at 2:20 PM, revealed the Social Service Worker attempted to interview Resident #2 without success. She documented the resident was sitting in a common area and was smiling. She documented observations of the resident, on 03/09/16 at 11:30 AM, and 03/10/16 at 2:00 PM, of the resident out of their room either beside the Nurses' Station or in the dining room smiling at staff when they spoke to him/her. No behaviors were noted. Interview with the Social Worker, on 03/29/16 at 12:15 PM, revealed she had observed the resident for three (3) days and saw no behaviors or negative outcome from the abuse. 7. Review of the clinical record revealed an order for [REDACTED]. Observation of Resident #2, on 03/15/16 at 3:24 PM, revealed the resident was in bed with Geri Sleeves applied. 8. Review of the training records revealed one hundred and sixty (160) employees had been trained by 03/18/16 by the Staff Development Nurse on the facility's Abuse Policy and had taken a post test. The only employees who had not received the abuse training were the four (4) employees on Family and Medical Leave Act (FMLA). Interview with CNA #9, on 03/16/16 at 8:30 AM, revealed she had recent training on abuse last week. She stated the training went over the Abuse Policy regarding protecting the resident first then reporting the abuse to the Nurse Supervisor. Interview with the Maintenance Director, on 03/16/16 at 8:40 AM, revealed he had training last week on the different types of abuse and what to do if abuse was witnessed. He stated he would report the abuse immediately to the nurse. Interview with Housekeeper #1, on 03/16/16 at 8:47 AM, revealed she received training on abuse last week. She stated a post test was given. Housekeeper #1 stated the different types of abuse were discussed and when and to whom to report the allegation of abuse. Interview with Occupational Therapist #1, on 03/16/16 at 8:50 AM, revealed she had received training on abuse many times. The most recent was last week. She stated the different types of abuse were discussed and how to report abuse and to whom. She stated the Abuse Hotline was discussed and the number was posted in the facility. Staff interviews, on 03/29/16 with LPN #8 at 1:26 PM, LPN #9 at 1:38 PM, LPN #7 at 1:42 PM, and LPN #6 at 1:55 PM, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) they had received re-education on the facility's Abuse Policy on the different types of abuse, how, when, and whom to report abuse. They had taken a post test and had to score 100%. Interview with CNA #12 at 1:30 PM and CNA #11 at 1:57 PM, revealed they had received recent training on abuse and had good knowledge on how, when, and to whom they were supposed to report allegations of abuse. They had to take a post test and score 100%. Interview with two (2) new employees (working under a Preceptor to become CNAs) on 03/29/16 at 1:35 PM, and 1:46 PM, revealed the new employees were both hired on 03/23/16. They stated they had received training on abuse during their classroom orientation regarding the different types of abuse, and how to report abuse. They were in the process of watching the Hand in Hand modules regarding abuse. In addition, they were required to take a post test and score 100%. 9. Review of the skin audits and resident interviews revealed the facility had conducted those audits as stated in the AOC. Interview with the Social Worker, on 03/29/16 at 12:15 PM, revealed she had conducted random audits of 10% of the daily census for interviews with the residents regarding abuse. She stated she ensured the residents knew to whom to report an allegation of abuse and that they felt comfortable. The Social Worker validated she received training on the Abuse Policy with a post test. She stated no resident had alleged any type of abuse during her interviews. Interview with the East Wing Unit Manager, on 03/29/16 at 2:00 PM, revealed she had received recent training on abuse from the DON. She then provided abuse training to the direct care staff starting on 03/08/16 and a post test was required. She stated she assisted the DON with audits of staff interview regarding their knowledge of how to report abuse. She also assisted in performing skin assessments on the residents. Interview with the West Wing Unit Manager, on 03/29/16 at 3:44 PM, revealed she just started the position on 03/24/16. She stated she received training on the Abuse Policy and took the required post test and scored 100%. The West Wing Unit Manager stated she had assisted in performing skin assessment audits and attended a QA meeting on 03/28/16. Interview with DON #3 and the Administrator, on 03/29/16 at 3:46 PM, revealed the facility had conducted audits (10% daily) of staff and residents through interviews to determine their knowledge of how to report abuse. The Administrator stated she implemented and educated the Abuse Coordinator Staff. She told the staff if the DON or the Administrator had not reached out to them after an allegation of abuse was received, they were to contact her. Daily skin assessments and resident interviews were conducted looking for any abuse. She stated the DON and Unit Managers would review the skin assessment audits and discuss in the morning meeting. The audits were then reviewed in the QA meetings. The Medical Director reviewed the corrective plans and was informed of the audits. She stated the IDT met every morning to review the audits and in the QA meetings. Interview with the Corporate Nurse Consultant, on 03/29/16 at 1:50 PM, revealed she had assisted with staff education, grading post tests, and reviewing daily audits. When she reviewed the audits; she wanted to ensure staff understood who and when to report abuse. The audits revealed staff had a good understanding of the abuse training that was provided with 100% score on the post test. She was providing oversight and working on survey readiness. She stated the new corporation was still implementing their polices and daily processes. However, she would be available for support and assistance and her goal was to visit the facility two (2) to three (3) times a week until compliance was achieved and then weekly. Review of the daily audits of staff interviews and the post test revealed five (5) staff were interviewed and given the examination daily. Interview with the Social Worker, on 03/28/16 at 12:15 PM, revealed she had been chosen for interview and post test frequently. Interview with LPN #8, on 03/29/16 at 1:26 PM, revealed she had been asked examination questions regarding her abuse training recently. Interview with CNA #9, on 03/29/16 at 1:28 PM, revealed she had been asked examination questions regarding the Abuse Policy since her training. 10. Review of the QA signature sheets revealed a QA meeting was conducted on 03/18/16 with the Medical Director participating via phone conference. In addition, those in attendance included: Administrator, DON, Social Worker, IDT team, and Human Resource Director. Interview with the Administrator, on 03/29/16 at 3:46 PM, revealed the QA meeting held on 03/18/16 was to discuss the survey findings and develop corrective plans. Review of the e-mail between the Administrator and the Medical Director, dated 03/18/16 at 8:18 PM, validated he participated in the QA meeting that day, had reviewed the Abuse Policy, and recommended no changes. He stated he agreed with the facility's plan of correction.
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy and investigation, it was determined the facility failed to ensure an allegation of physical abuse was immediately reported to the Administrator; and, failed to protect residents from further abuse for one (1) of twelve (12) sampled residents (Resident #2). On 03/02/16, during the evening meal, Certified Nursing Assistant (CNA) #4 slapped Resident #2 twice on the forearm. The incident was witnessed by CNA #2 and #3. However, the staff failed to immediately report the alleged abuse to the Charge Nurse per facility policy. The abuse allegation was not reported to the Administrator until 03/07/16 at approximately 10:30 PM. Interviews and review of CNA #4's time sheet revealed the aide continued to care for Resident #2 and other residents after the observed abuse. The facility's failure to have an effective system in place to ensure staff immediately reported observed abuse of residents; placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) was identified on 03/18/16 and determined to exist on 03/02/16. The facility was notified of the IJ on 03/18/16. An acceptable Allegation of Compliance (AOC) was received on 03/22/16, which alleged removal of the IJ on 03/19/16. A Partial Extended Survey was initiated on 03/28/16. The State Survey Agency (SSA) determined IJ was removed on 03/19/16 as alleged, which lowered the Scope and Severity (S/S) to D while the facility developed and implemented the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of systemic changes. The findings include: Review of the facility's Abuse and Neglect Policy, revised March 2013, revealed a person(s) who observed abuse would immediately report to the Charge Nurse. The Charge Nurse would immediately remove the suspected perpetrator from resident care, obtain the staff member's witness statement and immediately suspend the employee. The Charge Nurse would immediately notify the Administrator, Director of Nursing (DON), and/or Abuse Coordinator. The person(s) observing the incident would immediately report and provide a written statement that included the name of the resident, date and time it occurred, where it occurred, staff involved, and a description of what occurred. The Administrator or DON would notify state agencies according to the reporting guidelines. Review of the facility's investigation, dated 03/08/16, revealed CNA #2 reported to Registered Nurse (RN) #1 (on 03/07/16 at 7:15 PM) that she had observed CNA #4 smack Resident #2 on the arm last week. The Administrator and the Assistant Director of Nursing (ADON) were notified. The Administrator directed the nurse to interview CNA #4 and then suspend the aide. RN #1 documented CNA #4 admitted to swatting the resident's forearm when the resident attempted to grab at a food tray. The investigative report stated there were two (2) aides that had witnessed the abuse; however, they had not reported the abuse. The facility suspended the three (3) aides on 03/07/16. Review of the final report, dated 03/11/16, revealed the facility substantiated the allegation of abuse when CNA #4 admitted to hitting the resident on the forearm. The facility's investigation stated the two (2) aides that had witnessed the abuse (on 03/02/06 during the evening meal) had not reported the abuse. The facility notified the state agencies on 03/08/16. The local police were called, responded to the facility and took the information; however, stated they would not be pressing charges because it did not meet their criteria. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 07/24/09. Review of the most current [DIAGNOSES REDACTED]. The facility was unable to conduct a Brief Interview for Mental Status (BIMS) as the resident had a severe cognition loss. Review of the most recent Minimum Data Set (MDS) assessment, conducted on 02/22/16, revealed the resident required extensive assistance with eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD. RADCLIFF, KY 40160**	

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 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Review of the Comprehensive Care Plan, dated 02/22/16, addressing a communication deficit revealed Resident #2's communications skills were impaired and the resident was unable to understand or be understood. The goal directed staff to anticipate the needs of the resident. On 03/07/16, a new intervention was added to the care plan and instructed staff to place the resident's food tray out of the reach of the resident. Interview with CNA #3, on 03/15/16, at 4:57 PM, revealed he observed CNA #4 slap Resident #2's forearm in the dining room on 03/02/16. He stated CNA #4 was assisting Resident #2 with the evening meal when the resident reached for the food tray. He stated the resident had a history of [REDACTED]. When the resident reached for the food tray, CNA #4 slapped the resident on the forearm. The resident reached for the food tray again and the aide slapped the resident on the forearm again. He said the resident said, Ouch. He told the aide that he should not do that, but CNA #4 told him it was okay. He told the aide it was not okay. He stated License Practical Nurse (LPN) #5 was in the dining room when CNA #4 slapped the resident and he assumed she saw the same thing he witnessed. The nurse told him she would take care of it and he thought the nurse had reported the abuse. However, he did not see her speak with CNA #4 that night and the aide continued to care for residents. He said CNA #2 came to him several nights later (03/07/16) and said he needed to speak with RN #1 regarding what they observed in the dining room. He stated there was a miscommunication and he did not realize the alleged abuse had not been reported. He assumed LPN #5 had reported the abuse. A telephone interview with CNA #2, on 03/17/16 at 9:15 AM, revealed she had observed CNA #4 slap Resident #2 on the forearm twice on 03/02/16. She stated she did not report the allegation of abuse because a nurse was in the dining room at the same time of her observation and she assumed the nurse reported the abuse. She stated the resident was grabbing for a food tray and CNA #4 smacked the resident on the forearm with an opened hand. She said the resident reached for the food tray again and CNA #4 smacked the resident again on the forearm. However, this time the resident said,Ouch, and began rubbing his/her arm. The CNA stated she knew this was wrong, but since the nurse was in the dining room, she assumed she saw the same thing and would report the incident. When she saw CNA #4 working on 03/07/16 caring for residents, she realized the alleged abuse had not been reported. She stated she was uncomfortable with CNA #4 working with residents after what she observed and was afraid he would hit another resident in private. She then reported what she observed to a staff nurse. A telephone interview with LPN #5, on 03/16/16 at 8:49 PM, revealed she did not observe the alleged abuse and she had not reported any abuse. The nurse stated she was not in the dining room for the whole meal and did not witness the alleged abuse. She stated she was new to the facility and was still in the learning mode. She stated nobody came to her that night to report the alleged abuse. Review of CNA #4's work schedule and time sheet revealed the aide worked and cared for residents on March 2nd, 3rd, 5th, 6th, and 7th, 2016. Telephone interview with CNA #4, on 03/16/16 at 8:26 PM, revealed he denied hitting the resident, instead he said he pushed the resident's hand away. The aide stated the resident almost pulled the food tray onto the floor and he had held the resident's hand. However, he then touched the resident's arm. He stated he told the resident, No, No, while he was holding the resident's hand. The aide stated he continued to assist the resident with his/her meal and then transported the resident to the sunroom. Further interview revealed he continued to work with residents throughout the evening on 03/02/16. The aide validated he worked on March 3rd, 5th, 6th, and 7th, 2016 after the incident in the dining room caring for Resident #2. On 03/07/16, the aide stated a nurse came to him and told him he was suspended and had to go home. He said the Administrator called him a few days later and told him he was terminated. Interview with the Administrator and the current Director of Nursing (DON) #3, on 03/16/16 at 9:12 AM, revealed the alleged physical abuse was reported to them on 03/07/16 after CNA #2 reported the abuse to a nurse. Upon knowledge of the alleged abuse, CNA #4 was suspended on 03/07/16. The Administrator stated CNAs #2 and #3 were also suspended for not reporting the alleged abuse. She stated when CNA #4 was interviewed, he admitted to smacking the resident's forearm twice. She stated she terminated the aide because he could not understand what he did was wrong and she was not sure the aide would not slap another resident again. She stated she substantiated the allegation and the facility's investigation found the two (2) aides failed to report the alleged abuse to the nurse according to facility policy. The Administrator stated there were no changes made to the Abuse Policy. She stated that training of staff began on 03/08/16 and was ongoing. Interview with the Administrator and DON #3, on 03/17/16 at 4:25 PM, revealed the facility had not implemented any monitoring processes to ensure the training provided to staff was effective. DON #3, stated she had planned a staff meeting for 03/21/16 to go over the Abuse Policy and develop audits to ensure staff understood how to report abuse. However, they had not implemented those processes yet. The Administrator revealed she was waiting to have a Quality Assurance (QA) meeting scheduled for 03/24/16 after the monitoring audits were developed and implemented. The Administrator stated she was ensuring compliance through the complaint/grievance process. The facility implemented the following actions to remove the IJ: 1. The allegation of abuse against Resident #2 was reported to the State Agencies on 03/08/16. The facility's initial investigation was initiated on 03/07/16 by the Administrator, DON #2, and RN Nurse Manager. The facility suspended CNAs #2, #3, and #4 on 03/07/16. 2. The RN Unit Manager performed a skin assessment for Resident #2, on 03/07/16 and found no signs of abuse. On 03/10/16, skin assessments were conducted on those residents with a Brief Interview of Mental Status (BIMS) score of less than eight (8). No evidence of abuse was identified for any of those residents. 3. The facility (Social Services) interviewed residents with a BIMS score of eight (8) and above utilizing the Investigation Questions for Resident Interview, beginning on 03/08/16. 4. The Administrator notified the local law enforcement of the alleged abuse on 03/07/16. In addition, Resident #2's Physician and responsible party were notified of the alleged abuse on 03/07/16 by the RN Unit Manager. 5. The facility's Abuse Policy was reviewed by DON #3, Corporate Nurse Consultant and via telephone with the Medical Director on 03/07/16 and the Interdisciplinary Team on 03/18/16, with no revision required. 6. The Social Service Director assessed Resident #2 for possible psychosocial issues. No negative outcome was noted. 7. Resident #2's care plan was reviewed and revised on 03/07/16 by the RN Unit Manager. The care plan was revised to reflect a new order for Geri Sleeves to be applied to the resident's bilateral arms to prevent the resident from scratching his/her arms. 8. All staff received training on the Abuse Policy with a post test. Staff had to score 100% or retake the test. One hundred forty-one (141) out of one hundred sixty (160) employees received the training with the post test. Those who had not received the training were sent the training material with the post test via certified mail on 03/14/16. Employees will not be allowed to work until they had received the training and take the post test. The Staff Development Nurse will provide abuse training during the orientation program for all new employees. 9. Beginning 03/18/16, DON #3 and the Unit Managers would conduct random skin checks for residents with a BIMS' score less than eight (8) and Social Services would conduct interviews with residents with a BIMS' score greater than eight (8). The audits would be 10% of daily census for each group and conducted daily for two (2) weeks to ensure residents were free from abuse. The audits would decrease to 5% for five (5) days a week for two (2) weeks, then 5% three (3) times a week for one month. Staff interviews with a post test validation began on 03/18/16 where 10% of staff daily were given the abuse post test to ensure ongoing knowledge of various types of abuse and when and whom to report allegations of abuse. 10. An Ad Hoc QA meeting was conducted on 03/18/16 with the Medical Director via phone conference. The survey findings and AOC corrective plan were reviewed. The IDT team would meet weekly for four (4) weeks to review the audit findings until compliance is achieved. The SSA validated removal of the IJ on 03/19/16 as follows: 1. Review of the facility's investigation revealed the abuse investigation was initiated on 03/07/16 and the faxed report was sent to the Office of Inspector General (OIG) on 03/08/16 at 11:37 AM. Review of the Stakeholder Suspension Form, dated 03/17/16, revealed CNAs #2, #3, and #4 were suspended. CNA #2 and #3 received a counseling session on 03/09/16 for failure to follow the facility's policy and would be re-educated on the Abuse Policy. Interview with CNA #2, on 03/17/16 at 9:15 AM, revealed she had been suspended for not reporting the abuse. Interview with CNA #3, on 03/15/16, at 4:57 PM, revealed he had been suspended for not reporting the abuse. A telephone interview with CNA #4, on 03/16/16 at 8:26 PM, revealed he had been suspended on 03/07/16 and a few days later the Administrator had called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) and informed him he had been terminated. 2. Review of Resident #2's clinical record revealed a skin assessment was performed by the East Unit Manager, on 03/07/16 at 10:30 PM, with no bruises, only scratches noted to the underside of the resident's forearms, between the wrist and elbow. The resident's physician was notified of the scratches by the RN Unit Manager on 03/07/16 with an order for [REDACTED].>Interview with the RN Manager (now DON #3), on 03/15/16 at 9:10 AM, revealed she had called the resident's physician and obtained the order for the Geri Sleeves. Review of the AOC book revealed fifty-seven (57) skin assessments were conducted by the DON, Unit Managers and RN Charge Nurse on 03/10/16 with no evidence of abuse found. 3. Review of the resident's interviews revealed sixty-seven (67) residents were interviewed by Social Services beginning 03/08/16 with no concerns of abuse or mistreatment expressed. Interview with sampled Resident #1, on 03/16/16 at 8:25 AM, Resident #6 on 03/15/16 at 3:28 PM, Resident #7 on 03/16/16 at 10:02 AM, and Resident #9 on 03/28/16 at 9:37 AM, revealed the residents had not experienced any abuse and had not observed any abuse toward other residents. 4. Review of documentation with the local police contact information revealed the police was at the facility on 03/07/16. Interview with the Administrator and DON #3, on 03/16/16 at 9:12 AM, revealed the local police was called and came to the facility and tried to interview the resident. No charges were filed. DON #3 stated she had notified the resident's responsible party that night. On 03/07/16, DON #3 notified the Medical Director, who was on call as the resident's Primary Physician of the alleged abuse. 5. Review of the facility's Abuse Policy, dated March 2013, revealed no revisions were made. Interview with the Administrator, on 03/16/16 at 9:12 AM, revealed there had been no changes to the Abuse Policy. 6. Review of the Social Service Progress Note, dated 03/08/16 at 2:20 PM, revealed the Social Service Worker attempted to interview Resident #2 without success. She documented the resident was sitting in a common area and was smiling. She documented observations of the resident, on 03/09/16 at 11:30 AM, and 03/10/16 at 2:00 PM, of the resident out of their room either beside the Nurses' Station or in the dining room smiling at staff when they spoke to him/her. No behaviors were noted. Interview with the Social Worker, on 03/29/16 at 12:15 PM, revealed she had observed the resident for three (3) days and saw no behaviors or negative outcome from the abuse. 7. Review of the clinical record revealed an order for [REDACTED]. Observation of Resident #2, on 03/15/16 at 3:24 PM, revealed the resident was in bed with Geri Sleeves applied. 8. Review of the training records revealed one hundred and sixty (160) employees had been trained by 03/18/16 by the Staff Development Nurse on the facility's Abuse Policy and had taken a post test. The only employees that had not received the abuse training were the four (4) employees on Family and Medical Leave Act (FMLA). Interview with CNA #9, on 03/16/16 at 8:30 AM, revealed she had recent training on abuse last week. She stated the training went over the Abuse Policy regarding protecting the resident first then reporting the abuse to the Nurse Supervisor. Interview with the Maintenance Director, on 03/16/16 at 8:40 AM, revealed he had training last week on the different types of abuse and what to do if you witnessed abuse. He stated he would report the abuse immediately to the nurse. Interview with Housekeeper #1, on 03/16/16 at 8:47 AM, revealed she received training on abuse last week. She stated a post test was given. Housekeeper #1 stated the different types of abuse were discussed and when and to whom to report the allegation of abuse. Interview with Occupational Therapist #1, on 03/16/16 at 8:50 AM, revealed she had received training on abuse many times. The most recent was last week. She stated the different types of abuse were discussed and how to report abuse and to whom. She stated the Abuse Hotline was discussed and the number was posted in the facility. Staff interviews, on 03/29/16 with LPN #8 at 1:26 PM, LPN #9 at 1:38 PM, LPN #7 at 1:42 PM, and LPN #6 at 1:55 PM, revealed they had received re-education on the facility's Abuse Policy on the different types of abuse, how, when, and whom to report abuse. They had taken a post test and had to score 100%. Interview with CNA #12 at 1:30 PM and CNA #11 at 1:57 PM, revealed they had received recent training on abuse and had good knowledge on how, when, and to whom they were supposed to report allegations of abuse. They had to take a post test and score 100%. Interview with two (2) new employees (working under a Preceptor to become CNAs) on 03/29/16 at 1:35 PM, and 1:46 PM, revealed the new employees were both hired on 03/23/16. They stated they had received training on abuse during their classroom orientation regarding the different types of abuse, and how to report abuse. They were in the process of watching the Hand in Hand modules regarding abuse. In addition, they were required to take a post test and score 100%. 9. Review of the skin audits and resident interviews revealed the facility had conducted those audits as stated in the AOC. Interview with the Social Worker, on 03/29/16 at 12:15 PM, revealed she had conducted random audits of 10% of the daily census for interviews with the residents regarding abuse. She stated she ensured the residents knew to whom to report an allegation of abuse and that they felt comfortable. The Social Worker validated she received training on the Abuse Policy with a post test. She stated no resident had alleged any type of abuse during her interviews. Interview with the East Wing Unit Manager, on 03/29/16 at 2:00 PM, revealed she had received recent training on abuse from the DON. She then provided abuse training to the direct care staff starting on 03/08/16 and a post test was required. She stated she assisted the DON with audits of staff interview regarding their knowledge of how to report abuse. She also assisted in performing skin assessments on the residents. Interview with the West Wing Unit Manager, on 03/29/16 at 3:44 PM, revealed she just started the position on 03/24/16. She stated she received training on the Abuse Policy and took the required post test and scored 100%. The West Wing Unit Manager stated she had assisted in performing skin assessment audits and attended a QA meeting on 03/28/16. Interview with DON #3 and the Administrator, on 03/29/16 at 3:46 PM, revealed the facility had conducted audits (10% daily) of staff and residents through interviews to determine their knowledge of how to report abuse. The Administrator stated she implemented and educated the Abuse Coordinator Staff. She told the staff if the DON or the Administrator had not reached out to them after an allegation of abuse was received, they were to contact her. Daily skin assessments and resident interviews were conducted looking for any abuse. She stated the DON and Unit Managers would review the skin assessment audits and discuss in the morning meeting. The audits were then reviewed in the QA meetings. The Medical Director reviewed the corrective plans and was informed of the audits. She stated the IDT met every morning to review the audits and in the QA meetings. Interview with the Corporate Nurse Consultant, on 03/29/16 at 1:50 PM, revealed she had assisted with staff education, grading post tests, and reviewing daily audits. When she reviewed the audits; she wanted to ensure staff understood who and when to report abuse. The audits revealed staff had a good understanding of the abuse training that was provided with 100% score on the post test. She was providing oversight and working on survey readiness. She stated the new corporation was still implementing their polices and daily processes. However, she would be available for support and assistance and her goal was to visit the facility two (2) to three (3) times a week until compliance was achieved and then weekly. Review of the daily audits of staff interviews and the post test revealed five (5) staff were interviewed and given the examination daily. Interview with the Social Worker, on 03/28/16 at 12:15 PM, revealed she had been chosen for interview and post test frequently. Interview with LPN #8, on 03/29/16 at 1:26 PM, revealed she had been asked examination questions regarding her abuse training recently. Interview with CNA #9, on 03/29/16 at 1:28 PM, revealed she had been asked examination questions regarding the Abuse Policy since her training. 10. Review of the QA signature sheets revealed a QA meeting was conducted on 03/18/16 with the Medical Director participating via phone conference. In addition, those in attendance included: Administrator, DON, Social Worker, IDT team, and Human Resource Director. Interview with the Administrator, on 03/29/16 at 3:46 PM, revealed the QA meeting held on 03/18/16 was to discuss the survey findings and develop corrective plans. Review of the e-mail between the Administrator and the Medical Director, dated 03/18/16 at 8:18 PM, validated he participated in the QA meeting that day, had reviewed the Abuse Policy, and recommended no changes. He stated he agreed with the facility's plan of correction.
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.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185180		**04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's investigation report and policy, it was determined the facility failed to have an effective system in place to ensure the facility's policies and procedures related to reporting abuse and protection of residents were implemented for one (1) of twelve (12) sampled residents (Resident #2). Interview and record review revealed on 03/02/16, during the evening meal, two (2) Certified Nursing Assistants (CNA #2 and #3) witnessed CNA #4 slap Resident #2 twice on the forearm. The staff failed to follow its policies and procedures as they did not immediately report the alleged abuse to the charge nurse per facility policy. The physical abuse occurrence was not reported to the Charge Nurse until 03/07/16 at 7:30 PM five (5) days later. The abuse allegation was not reported to the Administrator until approximately 10:30 PM on 03/07/16, five (5) days after the occurrence of the event. Interviews and review of CNA #4's time sheet revealed the aide continued to care for Resident #2 and other residents after the observed abuse. Review of the work schedule and time sheet for CNA #4 revealed the aide worked and cared for resident on March 2, 3, 5, 6, and 7, 2016. The facility's failure to have an effective system in place to ensure staff reported observed abuse of residents immediately and ensure residents were protected from further abuse placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy (IJ) was identified on 03/18/16, and determined to exist on 03/02/16. The facility was notified of the IJ on 03/18/16. An acceptable Allegation of Compliance (AOC) was received on 03/22/16, which alleged removal of the IJ on 03/19/16. A Partial Extended Survey was initiated on 03/28/16. The State Survey Agency (SSA) determined the IJ was removed on 03/19/16 as alleged, which lowered the Scope and Severity (S/S) to D while the facility developed and implemented the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of systemic changes. The findings include: Review of the facility's Abuse and Neglect Policy, revised March 2013, revealed a person(s) who observed abuse would immediately report to the Charge Nurse immediately. The Charge Nurse would immediately remove the suspected perpetrator from resident care, obtain the staff member's witness statement and immediately suspend the employee. The Charge Nurse would immediately notify the Administrator, Director of Nursing (DON), and/or Abuse Coordinator. The person(s) observing the incident would immediately report and provide a written statement that included the name of the resident, date and time it occurred, where it occurred, staff involved, and a description of what occurred. The Administrator or DON would notify state agencies according to the reporting guidelines. Review of the facility's investigation, dated 03/08/16, revealed on 03/07/16 at 7:15 PM, CNA #2 reported to Registered Nurse (RN) #1 that she had observed CNA #4 smack Resident #2 on the arm last week. The Administrator and the Assistant Director of Nursing (ADON) were not notified until 10:30 PM on 03/07/16. The Administrator directed the nurse to interview CNA #4 and then suspend the aide. RN #1 documented CNA #4 admitted to swatting the resident's forearm when the resident attempted to grab at a food tray. Further review of the investigative report revealed there were two (2) aides that had witnessed the abuse; however, they had not reported the abuse. All three (3) aides were suspended on 03/07/16. Review of the final report, dated 03/11/16, revealed the facility substantiated the allegation of abuse when CNA #4 admitted to hitting the resident on the forearm. The facility's investigation revealed the two (2) aides that had witnessed the abuse (on 03/02/06 during the evening meal) had not followed the facility's policy, as they had not reported the abuse. The facility notified the state agencies on 03/08/16. The facility began education on their Abuse Policy on 03/08/16. Record review revealed the facility admitted Resident #2 in July 2009. The resident's [DIAGNOSES REDACTED]. The facility assessed the resident to have a severe cognition loss and was unable to conduct a Brief Interview of Mental Status (BIMS) test. Review of the most recent Minimum Data Set (MDS) assessment, conducted on 02/22/16, revealed the resident required extensive assistance with eating. Review of the Comprehensive Care Plan, for the problem of communication, dated 02/22/16, revealed the resident's communication was impaired and the resident was unable to understand or be understood. The goal was for the resident's needs to be anticipated by staff. A new intervention to place the resident's food tray out of reach of the resident, was added to the care plan on 03/07/16. Interview with CNA #3, on 03/15/16, at 4:57 PM, revealed he observed CNA #4 slap Resident #2's forearm in the dining room on 03/02/16. He stated CNA #4 was assisting Resident #2 with the evening meal when the resident reached for the food tray. He stated the resident had a history of [REDACTED]. When the resident reached for the food tray, CNA #4 slapped the resident on the forearm. When the resident reached for the food tray again, CNA #4 slapped the resident on the forearm again. CNA #3 stated the resident said, Ouch, the second time. CNA #3 told CNA #4 that he should not do that, but CNA #4 told him it was okay. CNA #3 told CNA #4 it was not okay. He stated License Practical Nurse (LPN) #5 was in the dining room when CNA #4 slapped the resident and he assumed she saw the same thing he witnessed. Further interview revealed the nurse told him she would take care of it and he thought the nurse had reported the abuse. However, he did not see her speak with CNA #4 that night and the aide continued to care for residents. He stated that CNA #2 came to him several nights later (03/07/16) and told him he needed to speak with RN #1 regarding what they observed in the dining room. He assumed that LPN #5 had reported the abuse. Interview, via telephone, with CNA #2, on 03/17/16 at 9:15 AM, revealed she had observed CNA #4 slap Resident #2 on the forearm twice on 03/02/16. She stated the resident grabbed for the food tray and CNA #4 smacked the resident on the forearm with an opened hand, and when the resident again reached for the food tray CNA #4 smacked the resident again on the forearm. However, this time the resident said,Ouch, and began rubbing his/her arm. Continued interview with CNA #2 revealed she did not report the allegation of abuse because a nurse was in the dining room at the same time. CNA #2 stated she knew this was wrong, but since the nurse was in the dining room, she assumed she saw the same thing and would report the incident. The CNA stated when she saw CNA #4 working on 03/07/16 caring for residents, she realized the alleged abuse had not been reported. She stated she was uncomfortable with CNA #4 working with residents after what she had observed. CNA #2 stated she was afraid he (CNA #4) would hit another resident in private. She then reported what she had observed to a staff nurse. Interview with LPN #5, on 03/16/16 at 8:49 PM, via telephone, revealed she did not observe the alleged abuse and she had not reported any abuse. LPN #5 stated she was not in the dining room for the whole meal and she did not witness the alleged abuse. She stated she was new to the facility and was still in the learning mode. She stated nobody came to her that night and reported the alleged abuse. Telephone interview with CNA #4, on 03/16/16 at 8:26 PM, revealed he denied hitting the resident, he stated he pushed the resident's hand away. The aide stated when the resident almost pulled the food tray onto the floor, he held the resident's hand. However, he then stated he touched the resident's arm. CNA #4 stated he told the resident, No, No, while he was holding the resident's hand. The aide stated he continued to assist the resident with his/her meal and then transported the resident to the sunroom and continued to work with residents throughout the evening on 03/02/16. The aide validated he worked on March 3, 5, 6, and 7, after the incident in the dining room caring for Resident #2. Further interview revealed on 03/07/16, a nurse came to him and told him he he had to go home, as he was suspended. A few days later the Administrator called him and told him he was terminated. Review of the work schedule and time sheet for CNA #4 revealed the aide worked on March 2, 3, 5, 6, and 7, 2016 caring for residents. Interview with the Administrator and the current Director of Nursing (DON) #3, on 03/16/16 at 9:12 AM, revealed the alleged physical abuse was reported to them on 03/07/16 after CNA #2 reported the abuse to a nurse. Upon knowledge of the alleged abuse, CNA #4 was suspended on 03/07/16. The Administrator stated CNAs #2 and #3 were also suspended for not following the facility's policy, as they did not report the alleged abuse. She stated when CNA #4 was interviewed, he admitted to smacking the resident's forearm twice. She stated she terminated the aide because he could not understand what he had done wrong and she was not sure the aide would not slap another resident again. She stated she substantiated the allegation and the facility's investigation found the that the two (2) aides failed to report the alleged abuse to the nurse according to the facility's policy. The Administrator stated there were no changes made to the Abuse Policy. She stated training of staff began on 03/08/16 and was ongoing. Interview with the Administrator and DON #3, on 03/17/16 at 4:25 PM, revealed the facility had not implemented any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	

(continued... from page 6)

monitoring processes to ensure the training provided to staff was effective. DON #3, stated she had planned a staff meeting for 03/21/16 to go over the Abuse Policy and develop audits to ensure staff understood how to report abuse. However, they had not implemented those processes yet. The Administrator revealed she was waiting to have a Quality Assurance (QA) meeting scheduled for 03/24/16 after the monitoring audits were developed and implemented. The Administrator stated she was ensuring compliance through the complaint/grievance process.

The facility implemented the following actions to remove the IJ:
1. The allegation of abuse against Resident #2 was reported to the State Agencies on 03/08/16. The facility's initial investigation was initiated on 03/07/16 by the Administrator, DON #2, and RN Nurse Manager. The facility suspended CNAs #2, #3, and #4 on 03/07/16.
2. The RN Unit Manager performed a skin assessment for Resident #2, on 03/07/16 and found no signs of abuse. On 03/10/16, skin assessments were conducted on those residents with a Brief Interview of Mental Status (BIMS) score of less than eight (8). No evidence of abuse was identified for any of those residents.
3. The facility (Social Services) interviewed residents with a BIMS score of eight (8) and above utilizing the Investigation Questions for Resident Interview, beginning on 03/08/16.
4. The Administrator notified the local law enforcement of the alleged abuse on 03/07/16. In addition, Resident #2's Physician and Responsible Party were notified of the alleged abuse on 03/07/16 by the RN Unit Manager.
5. The facility's Abuse Policy was reviewed by DON #3, Corporate Nurse Consultant and via telephone with the Medical Director on 03/07/16 and the Interdisciplinary Team on 03/18/16, with no revision required.
6. The Social Service Director assessed Resident #2 for possible psychosocial issues. No negative outcome was noted.
7. Resident #2's care plan was reviewed and revised on 03/07/16 by the RN Unit Manager. The care plan was revised to reflect a new order for Geri Sleeves to be applied to the resident's bilateral arms to prevent the resident from scratching his/her arms.
8. All staff received training on the Abuse Policy with a post test. Staff had to score 100% or retake the test. One hundred forty-one (141) out of one hundred sixty (160) employees received the training with the post test. Those who had not received the training were sent the training material with the post test via certified mail on 03/14/16. Employees will not be allowed to work until they had received the training and taken the post test. The Staff Development Nurse will provide abuse training during the orientation program for all new employees.
9. Beginning 03/18/16, DON #3 and the Unit Managers would conduct random skin checks for residents with a BIMS score less than eight (8) and Social Services would conduct interviews with residents with a BIMS' score greater than eight (8). The audits would be 10% of daily census for each group and conducted daily for two (2) weeks to ensure residents were free from abuse. The audits would decrease to 5% for five (5) days a week for two (2) weeks, then 5% three (3) times a week for one month.
Staff interviews with a post test validation began on 03/18/16 where 10% of staff daily were given the abuse post test to ensure ongoing knowledge of various types of abuse and when and whom to report allegations of abuse.
10. An Ad Hoc QA meeting was conducted on 03/18/16 with the Medical Director via phone conference. The survey findings and AOC corrective plan were reviewed. The IDT team would meet weekly for four (4) weeks to review the audit findings until compliance is achieved.
The SSA validated removal of the IJ on 03/19/16 as follows:
1. Review of the facility's investigation revealed the abuse investigation was initiated on 03/07/16 and the faxed report was sent to the Office of Inspector General (OIG) on 03/08/16 at 11:37 AM. Review of the Stakeholder Suspension Form, dated 03/17/16, revealed CNAs #2, #3, and #4 were suspended. CNA #2 and #3 received a counseling session on 03/09/16 for failure to follow the facility's policy and would be re-educated on the Abuse Policy.
Interview with CNA #2, on 03/17/16 at 9:15 AM, revealed she had been suspended for not reporting the abuse. Interview with CNA #3, on 03/15/16, at 4:57 PM, revealed he had been suspended for not reporting the abuse. A telephone interview with CNA #4, on 03/16/16 at 8:26 PM, revealed he had been suspended on 03/07/16 and a few days later the Administrator had called and informed him he had been terminated.
2. Review of Resident #2's clinical record revealed a skin assessment was performed by the East Unit Manager, on 03/07/16 at 10:30 PM, with no bruises, only scratches noted to the underside of the resident's forearms, between the wrist and elbow. The resident's physician was notified of the scratches by the RN Unit Manager on 03/07/16 with an order for [REDACTED].>Interview with the RN Manager (now DON #3), on 03/15/16 at 9:10 AM, revealed she had called the resident's physician and obtained the order for the Geri Sleeves.
Review of the AOC book revealed fifty-seven (57) skin assessments were conducted by the DON, Unit Managers and RN Charge Nurse on 03/10/16 with no evidence of abuse found.
3. Review of the resident's interviews revealed sixty-seven (67) residents were interviewed by Social Services beginning 03/08/16 with no concerns of abuse or mistreatment expressed.
Interview with sampled Resident #1, on 03/16/16 at 8:25 AM, Resident #6 on 03/15/16 at 3:28 PM, Resident #7 on 03/16/16 at 10:02 AM, and Resident #9 on 03/28/16 at 9:37 AM, revealed the residents had not experienced any abuse and had not observed any abuse toward other residents.
4. Review of documentation with the local law enforcement contact information revealed the police were at the facility on 03/07/16.
Interview with the Administrator and DON #3, on 03/16/16 at 9:12 AM, revealed the local police was called and came to the facility and tried to interview the resident. No charges were filed. DON #3 stated she had notified the resident's responsible party that night. On 03/07/16, DON #3 notified the Medical Director, who was on call as the resident's Primary Physician of the alleged abuse.
5. Review of the facility's Abuse Policy, dated March 2013, revealed no revisions were made.
Interview with the Administrator, on 03/16/16 at 9:12 AM, revealed there had been no changes to the Abuse Policy.
6. Review of the Social Service Progress Note, dated 03/08/16 at 2:20 PM, revealed the Social Service Worker attempted to interview Resident #2 without success. She documented the resident was sitting in a common area and was smiling. She documented observations of the resident, on 03/09/16 at 11:30 AM, and 03/10/16 at 2:00 PM, of the resident out of their room either beside the Nurses' Station or in the dining room smiling at staff when they spoke to him/her. No behaviors were noted.
Interview with the Social Worker, on 03/29/16 at 12:15 PM, revealed she had observed the resident for three (3) days and saw no behaviors or negative outcome from the abuse.
7. Review of the clinical record revealed an order for [REDACTED].
Observation of Resident #2, on 03/15/16 at 3:24 PM, revealed the resident was in bed with Geri Sleeves applied.
8. Review of the training records revealed one hundred and sixty (160) employees had been trained by 03/18/16 by the Staff Development Nurse on the facility's Abuse Policy and had taken a post test. The only employees that had not received the abuse training were the four (4) employees on Family and Medical Leave Act (FMLA).
Interview with CNA #9, on 03/16/16 at 8:30 AM, revealed she had recent training on abuse last week. She stated the training went over the Abuse Policy regarding protecting the resident first then reporting the abuse to the Nurse Supervisor.
Interview with the Maintenance Director, on 03/16/16 at 8:40 AM, revealed he had training last week on the different types of abuse and what to do if you witnessed abuse. He stated he would report the abuse immediately to the nurse.
Interview with Housekeeper #1, on 03/16/16 at 8:47 AM, revealed she received training on abuse last week. She stated a post test was given. Housekeeper #1 stated the different types of abuse were discussed and when and to whom to report the allegation of abuse.
Interview with Occupational Therapist #1, on 03/16/16 at 8:50 AM, revealed she had received training on abuse many times. The most recent was last week. She stated the different types of abuse were discussed and how to report abuse and to whom. She stated the Abuse Hotline was discussed and the number was posted in the facility.
Staff interviews, on 03/29/16 with LPN #8 at 1:26 PM, LPN #9 at 1:38 PM, LPN #7 at 1:42 PM, and LPN #6 at 1:55 PM, revealed they had received re-education on the facility's Abuse Policy on the different types of abuse, how, when, and whom to report abuse. They had taken a post test and had to score 100%.
Interview with CNA #12 at 1:30 PM and CNA #11 at 1:57 PM, revealed they had received recent training on abuse and had good

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD. RADCLIFF, KY 40160**

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 0226

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 7)
knowledge on how, when, and to whom they were supposed to report allegations of abuse. They had to take a post test and score 100%.
Interview with two (2) new employees (working under a Preceptor to become CNAs) on 03/29/16 at 1:35 PM, and 1:46 PM, revealed the new employees were both hired on 03/23/16. They stated they had received training on abuse during their classroom orientation regarding the different types of abuse, and how to report abuse. They were in the process of watching the Hand in Hand modules regarding abuse. In addition, they were required to take a post test and score 100%.
9. Review of the skin audits and resident interviews revealed the facility had conducted those audits as stated in the AOC.
Interview with the Social Worker, on 03/29/16 at 12:15 PM, revealed she had conducted random audits of 10% of the daily census for interviews with the residents regarding abuse. She stated she ensured the residents knew to whom to report an allegation of abuse and that they felt comfortable. The Social Worker validated she received training on the Abuse Policy with a post test. She stated no resident had alleged any type of abuse during her interviews.
Interview with the East Wing Unit Manager, on 03/29/16 at 2:00 PM, revealed she had received recent training on abuse from the DON. She then provided abuse training to the direct care staff starting on 03/08/16 and a post test was required. She stated she assisted the DON with audits of staff interview regarding their knowledge of how to report abuse. She also assisted in performing skin assessments on the residents.
Interview with the West Wing Unit Manager, on 03/29/16 at 3:44 PM, revealed she just took that position on 03/24/16. She stated she received training on the Abuse Policy and took the required post test and scored 100%. The West Wing Unit Manager stated she had assisted in performing skin assessment audits and attended a QA meeting on 03/28/16.
Interview with DON #3 and the Administrator, on 03/29/16 at 3:46 PM, revealed the facility had conducted audits (10% daily) of staff and residents through interviews to determine their knowledge of how to report abuse. The Administrator stated she implemented and educated the Abuse Coordinator Staff. She told the staff if the DON or the Administrator had not reached out to them after an allegation of abuse was received, they were to contact her. Daily skin assessments and resident interviews were conducted looking for any abuse. She stated the DON and Unit Managers would review the skin assessment audits and discuss in the morning meeting. The audits were then reviewed in the QA meetings. The Medical Director reviewed the corrective plans and was informed of the audits. She stated the IDT met every morning to review the audits and in the QA meetings.
Interview with the Corporate Nurse Consultant, on 03/29/16 at 1:50 PM, revealed she had assisted with staff education, grading post tests, and reviewing daily audits. When she reviewed the audits; she wanted to ensure staff understood who and when to report abuse. The audits revealed staff had a good understanding of the abuse training that was provided with 100% score on the post test. She was providing oversight and working on survey readiness. She stated the new corporation was still implementing their polices and daily processes. However, she would be available for support and assistance and her goal was to visit the facility two (2) to three (3) times a week until compliance was achieved and then weekly.
Review of the daily audits of staff interviews and the post test revealed five (5) staff were interviewed and given the examination daily. Interview with the Social Worker, on 03/28/16 at 12:15 PM, revealed she had been chosen for interview and post test frequently. Interview with LPN #8, on 03/29/16 at 1:26 PM, revealed she had been asked examination questions regarding her abuse training recently. Interview with CNA #9, on 03/29/16 at 1:28 PM, revealed she had been asked examination questions regarding the Abuse Policy since her training.
10. Review of the QA signature sheets revealed a QA meeting was conducted on 03/18/16 with the Medical Director participating via phone conference. In addition, those in attendance included: Administrator, DON, Social Worker, IDT team, and Human Resource Director.
Interview with the Administrator, on 03/29/16 at 3:46 PM, revealed the QA meeting held on 03/18/16 was to discuss the survey findings and develop corrective plans. Review of the e-mail between the Administrator and the Medical Director, dated 03/18/16 at 8:18 PM, validated he participated in the QA meeting that day, had reviewed the Abuse Policy, and recommended no changes. He stated he agreed with the facility's plan of correction.

F 0281

Level of harm - Immediate jeopardy

Residents Affected - Some

Make sure services provided by the nursing facility meet professional standards of quality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, record review and policy review, it was determined the facility failed to ensure all applicants for nursing positions had a current license before caring for residents. The facility allowed an Unlicensed Graduate Nurse to work as a licensed nurse performing all nursing duties independently, placing all residents the nurse cared for at risk for harm or death. The Unlicensed Graduate Nurse cared for residents on one (1) of the two (2) units that had four (4) hallways, involving potentially forty-six (46) residents. Kentucky Board of Nursing (KBN) Laws KRS 314.051 and KRS 314.031
In addition, the facility failed to implement the interim care plan for one (1) of twelve (12) sampled residents (Resident #4). The resident was assessed by the facility to be at high risk for falls. The facility failed to provide appropriate assistance during a shower; the resident fell sustaining fractures to the left humerus,7th left rib, and 9th [MEDICATION NAME] vertebrae.
The facility's failure to ensure all nursing staff had a current license and was qualified to perform nursing duties, as well as ensure staff implemented the interim care plan for residents placed residents at risk for severe injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 03/30/16; the facility was notified on 03/30/16.
The facility provided an acceptable Allegation of Compliance (AOC) on 04/04/16, which alleged removal of the IJ on 04/05/16. The State Survey Agency (SSA) verified the IJ was not removed on 04/05/16 as alleged. It was determined the IJ was removed on 04/07/16 (facility allowed a nurse to return to work without training on 04/06/16) prior to exit on 04/08/16. The Scope and Severity (S/S) was lowered to an G while the facility develops and implements the plan of correction and the Quality Assurance (QA) monitors for effectiveness of the systemic changes.
The findings include:
1. Review of the facility's Licensure and Certification Compliance Functions Policy, revised November 2015, revealed it was the policy of the company that all positions requiring professional licenses or certifications would be filled only by persons holding such licenses or certifications.
Review of the facility's Stakeholders Orientation Policy, effective 2008, revealed it was the policy of the company that Stakeholders attend Orientation within two (2) weeks of date of hire.
Interview with the Nurse Consultant, on 03/30/16 at 4:42 PM, revealed the facility did not have a policy on Licensed Practical Nurse Applicants (LPNA), Registered Nurse Applicants (RNA), or Student Nurses. The facility was in the process for developing one.
Review of the Kentucky Board of Nursing Law, KRS 314.051 revealed an LPNA shall only work under the direct supervision of a nurse and shall not engage in independent nursing practice. No other person shall assume the title or use the abbreviation or any other words, letters, signs, or figures to indicate that the person using the same is a licensed practical nurse. No person shall practice as a licensed practical nurse unless licensed under this chapter. Refer to KBN 314.031
Review of the KBN website, with a copyright date of 2016, revealed a provisional license would be issued within fourteen (14) days of meeting all application requirements. The provisional license would be valid for a period of six (6) months from the date issued. It instructed the potential employee to not begin employment as an Licensed Practical Nurse Applicant (LPNA) until they had been issued a provisional license by the KBN.
Review of the Unlicensed Graduate Nurse's employee file, revealed she was hired as an LPNA on 11/30/15 (under the previous corporation) and was to start work on the second (2nd) shift. There was no evidence in the employee's file of a provisional license to work as a Nurse Applicant.
Review of the Charge Nurse (Licensed Practical Nurse (LPN) or Registered Nurse (RN) Job Description, dated 12/04/15, had LPNA hand written on the top. The Unlicensed Graduate Nurse signed the job description for a LPN Charge Nurse. Review of the Job Description Summary, revealed a LPNA would provide direct nursing care to the residents and supervise the day-to-day nursing activities performed by nursing assistants. The job description further stated such supervision must be in accordance with current Federal, State and Local standards, guidelines, and regulations that govern the facility, and as may also be required by the Director of Nursing to maintain the highest degree of quality care at all times. Some Essential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) Duties and Responsibilities were: to direct the day-to-day functions of the nursing assistants in accordance with rules; regulations and confirm that all nursing personnel assigned comply with the written policies and procedures; make written and oral reports/recommendations concerning the activities of your shift; periodically review the residents' written discharge plans; participate in the updating of the residents' written discharge plans; admit transfer and discharge residents; complete accident and incident reports as necessary; complete and file required forms/charts; receive telephone orders from physicians and record on the physician's orders [REDACTED]. reflect that the care plan was being followed when administering nursing care or treatment; prepare and administer medication; order prescribed medications; verify narcotic records were accurate; make rounds with the physicians; and, consult with the resident's physician. The Job Requirement stated the nurse was to have the ability to work with minimal supervision, take initiative and make independent decisions. Review of the Unlicensed Graduate Nurse's Employee Schedule, dated 12/02/15, 12/03/15, 12/04/15, 12/07/15 and 12/08/15 revealed she worked on the unit with a Preceptor. However, on 12/10/15 the Unlicensed Graduate Nurse began to work the Rehabilitation Unit by herself, with no Preceptor. Review of the Unlicensed Graduate Nurse's employee file, revealed no evidence that an orientee checklist had been completed by the Preceptor. Interview with Licensed Practical Nurse (LPN) #8, on 03/29/16 at 4:00 PM, revealed she witnessed the Unlicensed Graduate Nurse work as a nurse on the 600 Unit (Rehabilitation Unit). LPN #8 stated she completed narcotic counts and gave report to the Unlicensed Graduate Nurse. Further interview with LPN #8 revealed she was not aware that the Unlicensed Graduate Nurse did not have a nursing or provisional (temporary) license. Interview with Registered Nurse (RN) #3, on 03/30/16 at 2:56 PM, revealed she precepted the Unlicensed Graduate Nurse and taught her the daily operations such as; taking telephone orders, documenting and doing assessments. RN #3 stated she was not required to sign behind the orientee. She stated when completing medication pass or treatments she had the orientee sign off that the medication was given or that the treatment was completed. Further interview with RN #3 revealed she also had the orientee sign if she administered a narcotic. RN #3 stated she was aware the Unlicensed Graduate Nurse was a new nurse, but did not know she did not have a license. She stated she remembered a check list that the Unlicensed Graduate Nurse kept with her. RN #3 stated she precepted the Unlicensed Graduate Nurse for one (1) to two (2) days; and, then the Unlicensed Graduate Nurse started working on the West Wing (Rehabilitation Unit) on second (2nd) shift, by herself. Interview with Registered Nurse (RN) #1, on 03/31/16 at 8:55 AM, revealed she had precepted new nurses during orientation. RN #1 stated there had been some nurses who had an orientee checklist and some who did not have the checklist. When the Unlicensed Graduate Nurse was hired the facility did not have a policy regarding orientation checklists; however, according to the new corporation's facility's policy, all orientees should have a orientation check list. RN #1 stated she had also precepted new graduate applicant nurses. She stated she would observe them do their tasks and then she would sign that the task had been completed; the nurse applicant did not sign that the tasks had been completed. Interview with RN #2, on 03/31/16 at 10:15 AM, revealed she worked from 6:30 AM to 6:30 PM and had precepted the Unlicensed Graduate Nurse. RN #2 stated she remembered educating the Unlicensed Graduate Nurse on the facility's nursing forms; Medication Administration Records, Treatment records, telephone orders, and how to complete a proper medication pass. RN #2 stated she remembered there was an orientee checklist on how to provide tracheotomy care, wounds, gastric tubes, vitals and assessments. RN #2 stated she did not remember the Unlicensed Graduate Nurse providing a new orientee checklist for review. She stated she was not aware the Unlicensed Graduate Nurse did not have a provisional license to work. RN #2 stated she would not have taken on the preceptor role for someone who did not have a license (provisional or regular). RN #2 stated she was with the Unlicensed Graduate Nurse the whole time she precepted with her. She stated she thought the Unlicensed Graduate Nurse was an LPNA and had not sat for her nursing boards yet. Interview with the Staff Development Coordinator (SDC), on 03/29/16 at 11:35 AM, revealed the Preceptor was responsible for the hands on training of staff. New Orientees were given a minimum of five (5) days on the unit for training. The SDC stated the Unlicensed Graduate Nurse did all of the activities a LPN did, such as medication pass, treatments, laboratory draws and antibiotic therapy, including using an intravenous (IV) access. Interview with the Unlicensed Graduate Nurse, on 03/31/16 at 10:30 AM, revealed she functioned as a LPN and completed such tasks as medication pass, treatments, initiated care plans, took off physician's orders [REDACTED]. The Unlicensed Graduate Nurse stated she worked all shifts and at night she would have as many as two (2) halls on the West Unit. She stated no one followed up with the care she provided. Further interview with the Unlicensed Graduate Nurse revealed she was given a name badge that stated LPN and her name badge was never corrected by Unit Manager #1 on the West Hall. Review of Narcotic Record Sheets for Resident #4, revealed Unlicensed Graduate Nurse provided Zolipem [MEDICATION NAME] (Sleeping pill) five (5) Milligrams (mg) on 02/10/16 at 9:00 PM. There was no written documentation that another licensed staff member signed that they had witnessed the Unlicensed Graduate Nurse complete this task. Review of the Narcotic Record Sheets for Resident #5, revealed the Unlicensed Graduate Nurse [MEDICATION NAME](sleeping pill)10 mg to the resident on 02/24/16 at 8:00 PM. In addition, the Unlicensed Graduate Nurse completed the full Nursing Assessment; she took vitals, reviewed the resident's past surgical history, assessed the resident's cognition, communication, bed mobility, transfer status, dressing, eating, toileting, and hygiene status. The Unlicensed Graduate Nurse assessed Resident #5's neurological, respiratory, gastrointestinal, cardiovascular and urinary systems. Further review revealed the Unlicensed Graduate Nurse documented a full skin assessment of the resident, noting that the resident had a surgical wound to his/her coccyx. The Unlicensed Graduate Nurse completed a pressure ulcer risk assessment, pain evaluation and falls' risk evaluation for Resident #5. All of these tasks were completed with no staff member observing or signing that they witnessed that these actions occurred. Review of Unsampled Resident B's Daily Skilled Nurses' Notes, dated, 03/06/16, 03/08/16, 03/09/16 and 03/10/16, revealed the Unlicensed Graduate Nurse monitored and administered Gastrostomy-tube ([DEVICE]) feeding to ensure Glucerna (supplemental feeding) was being administered at forty-five (45) cubic centimeters per hour (cc/hr). The Unlicensed Graduate Nurse administered Humalog (insulin) per sliding scale to Unsampled Resident B, on 01/08/16, 01/09/16, 01/10/16 and 01/11/16. The Unlicensed Graduate Nurse administered an Levimir Flex Pen (insulin) on 01/08/16, 01/09/16, 01/10/16 and 01/11/16. Further review revealed the Unlicensed Graduate Nurse completed [MEDICATION NAME] (blood thinner) flushes of three (3) milliliters (ml) with a Normal Saline flush of five (5) ml in Unsampled Resident B's Peripherally Inserted Central Catheter (PICC) line (for intravenous administration of medications), on 03/08/16, 03/09/16 and 03/10/16. No staff member signed that they witnessed the Unlicensed Graduate Nurse complete these tasks. Review of Unsampled Resident C's MAR, dated 03/08/16, 03/09/16; and, on 03/11/16, revealed the Unlicensed Graduate Nurse administered [MEDICATION NAME] (breathing treatments) treatments at 6:00 PM. No staff member signed that they witnessed the Unlicensed Graduate Nurse complete these tasks. Review of Unsampled Resident D's Medication Administration Record (MAR) and Treatment Administration Record (TAR), revealed Un-sampled Resident D had a [DIAGNOSES REDACTED]. The MAR and TAR also revealed the Unlicensed Graduate Nurse signed that she checked the placement and residual (feeding left in the stomach) of the [DEVICE] prior to administering medications, flushed the [DEVICE] with thirty (30) milliliters (ml) of water after each medication administration, cleaned the [DEVICE] site during her shift. No staff member signed that they witnessed the Unlicensed Graduate Nurse complete the tasks. Review of Unsampled Resident E's Nursing Admission Information sheet, dated 02/16/16 at 7:00 PM, revealed the Unlicensed Graduate Nurse completed the full Nursing Assessment; she took vital signs, reviewed the resident's past surgical history, assessed the resident's cognition, communication, bed mobility, transfer status, dressing, eating, toileting, and hygiene status. The Unlicensed Graduate Nurse assessed the resident's Vascular Access Device (Port-Cath) (a device implanted under the skin to receive medications) and stated there was no redness, swelling or drainage. The Unlicensed Graduate Nurse assessed Unsampled Resident E's neurological, respiratory, gastrointestinal, cardiovascular and urinary systems. The Unlicensed Graduate Nurse documented a full skin assessment of the resident, noting the resident had tissue damage to his/her feet. Further review of the clinical record revealed the Unlicensed Graduate Nurse completed a pressure ulcer risk assessment, pain evaluation and fall risk evaluation for Unsampled Resident E. All of these tasks were completed with no staff member signing that they witnessed these actions completed. Review of Narcotic Record sheets for Unsampled Resident F, revealed the Unlicensed Graduate Nurse provided [MEDICATION NAME]-[MEDICATION NAME] (pain medication) 5/325 mg on 01/17/16, 01/18/16, 01/19/16, 01/20/16, 01/21/16 and, on 01/24/16 at 8:00 PM. No staff member signed that they witnessed the Unlicensed Graduate Nurse complete the tasks. Review of Narcotic Record sheets, for Unsampled Resident H, revealed the Unlicensed Graduate Nurse provided [MEDICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD. RADCLIFF, KY 40160**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) NAME]-APAP ([MEDICATION NAME]) (pain medication) 5/325 mg on 01/05/16 at 8:00 PM. There was no documented evidence that another staff member signed that they witnessed the Unlicensed Graduate Nurse complete these tasks. Review of the Narcotic Record sheets, for Unsampled Resident I, revealed the Unlicensed Graduate Nurse provided [MEDICATION NAME]-APAP 5/325 mg on 02/18/16 at 5:30 PM; and, on 02/20/16 at 10:00 PM. No staff member signed that they witnessed the Unlicensed Graduate Nurse complete these tasks. Review of the Midnight Nursing Census, revealed the Unlicensed Graduate Nurse provided care to as many as forty-two (42) residents at one time by herself with no preceptor, with no one ensuring she was performing these tasks correctly. Interview with the Staff Development Coordinator, on 03/30/16 at 10:37 AM, revealed the process for monitoring a nurse with a provisional license, was to monitor until the nurse was comfortable on the unit. The Staff Development Coordinator stated some nurses with provisional licenses could ask for more time with orientation if they needed the help. She stated the Preceptor was the person who reviewed the provisional licensed nurse's work, but they did not have to sign that they witnessed the licensed nurse's care. The Staff Development Coordinator stated there was no policy that stated the Preceptor had to co-sign each document the provisional licensed nurse signed. The Staff Development Coordinator stated she did not monitor to ensure the provisional licensed nurses completed competencies. She further stated she did not give any oversight. However, the Unlicensed Graduate Nurse did not have a provisional license and could not work independently. The KBN instructed the potential employee to not begin employment or function as an LPNA until they had been issued a provisional license by the KBN. Interview with the Staff Development Coordinator (SDC), on 03/30/16 at 8:55 AM, revealed there was no oversight with the preceptor educating nurse applicants. She stated she did go over Foley (brand of indwelling catheter) catheter care, reach care and core competencies once a year. Interview via telephone with Director of Nursing (DON) #2, on 03/31/16 at 9:28 AM, revealed when the Unlicensed Graduate Nurse worked, there was always a Registered Nurse (RN) on the unit. DON #2 stated the rule was for an RN to supervise the Unlicensed Graduate Nurse. The DON could not say if that was everyday; there was not always an RN during the night shift while she was the DON. DON #2 stated she felt the Unlicensed Graduate Nurse could complete a medication pass and do treatments with a provisional license as long as an RN was available for questions. However, this Unlicensed Graduate Nurse did not have a provisional license. Interview with DON #3, on 03/29/16 at 10:55 AM, revealed there should not be any new graduates on the therapy (rehabilitation) halls. She stated only experienced nurses were to work the rehabilitation halls, because the care was like a medical surgical unit. DON #3 stated that nursing judgement, assessments and skills were needed on the Rehabilitation Hall. Interview with the Staff Development Coordinator (SDC), on 03/31/16 at 10:00 AM, revealed she did not receive a competency check off list from the Unlicensed Graduate Nurse. The SDC stated that a new hire had ninety (90) days to turn in the check off list. She stated she did not ask the graduate nurse for the documentation and she did not think it was concerning to have the graduate nurse work without the SDC having the checklist to verify because the prior corporation did not require the checklist, nor did they have a process to monitor the orientation. 2. Review of the facility's Interim Plan of Care Policy, last reviewed 06/01/15, revealed an interim care plan would be developed to meet the resident's immediate needs within twenty-four hours of the resident's admission. The Interim Care Plan would be used until a comprehensive assessment could be conducted and an interdisciplinary care plan was developed. The Interdisciplinary Team would review the physician's orders [REDACTED]. In addition, the nursing evaluation, history and physical, discharge summary report and other pertinent information were to be reviewed. Closed record review of Resident #4's clinical record revealed the facility admitted the resident on 01/15/16 at 11:30 PM with [DIAGNOSES REDACTED]. Review of the Nursing Admission Assessment, dated 01/15/16, revealed the nurse assessed the resident to require assistance of two (2) staff for bed mobility, transfers, and ambulation. The Fall Risk Evaluation (included in the Admission Assessment) identified the resident as high risk for falling due to a score of eleven (11), (a score above ten (10) was a high risk) with a problem with balance. The nurse assessed the resident's balance to be unsteady, and only able to stabilize with physical assistance. Further review of the Fall Assessment revealed the resident had a fall on 01/11/16 prior to admission. Review of the Interim Care Plan, dated 01/15/16, revealed falls were identified as a problem with interventions to verbally remind the resident not to ambulate alone and observe for any unsafe actions and intervene as needed. Continued review of the clinical record revealed the resident's Interim Care Plan was not developed until 02/04/16, to address the resident's injurious fall. Review of a Nurse's Note, dated 01/20/16 at 8:45 PM, revealed the resident was in the shower room with Certified Nursing Assistant (CNA)#5, when he/she attempted an unassisted transfer, and fell on to the wet shower floor. The Note stated the resident tried to catch himself/herself and suffered skin tears to his/her bilateral forearms and complained of severe pain in his/her left shoulder. The Nurse Practitioner was called and an order was received to send the resident to the emergency room for evaluation of the fall. The resident was transferred to a Trauma Center and then placed in the Intensive Care Unit for management of multiple medical problems including fractures to the left humerus, 7th left rib, and 9th [MEDICATION NAME] vertebrae. The resident was in the hospital from 01/21/16 through 01/26/16. Refer to F323. Interview with CNA #8, on 03/17/16 at 2:40 PM, revealed this was the first time he had given Resident #4 a shower and he thought the resident only required supervision with transfers. He had finished bathing the resident and turned around to get his/her clothing to dress the resident. CNA #8 stated he stepped away from the resident a short distance to the sink counter where the resident's clothing was located. He said he saw the resident take a step out of the shower chair and slip on the wet shower floor, face first. CNA #8 stated he thought the nurse aide care plan stated the resident required only supervision with transfers. Request for the nurse aide care plan revealed it was the facility's process not to keep the nurse aide care plans. Once a resident was discharged from the facility, the nurse aide care plan was deleted. The facility could not provide any documented evidence the nurse aide care plan instructed the nurse aides to transfer the resident with supervision only. Interview with the West Wing Unit Manager #1, on 03/17/16 at 3:10 PM, revealed she conducted the fall investigation for Resident #4. She revealed she was not at the facility when the fall occurred, but investigated the fall the next day. She stated she didn't recall what mode of transfer was on the nurse aide care plan before the resident's fall. Further interview revealed she could not provide a copy of the care plan since the resident had been discharged from the facility. Interview with the West Wing Unit Manager #1, on 03/17/16 at 5:37 PM, revealed the facility used the interim care plan until the comprehensive care plan was developed. The resident's care needs (including transfer mode) were communicated to the nurse aides through their care plans. A telephone interview with CNA #7, on 03/17/16 at 6:45 PM, revealed she had cared for Resident #4 on 01/19/16. She stated the resident required assistance of one person for transfers. She stated the resident used an electric wheelchair and was independent once in the chair. She stated the nurse aide care plan instructed staff to transfer the resident with two (2) persons. Interview with Licensed Practical Nurse (LPN) #11, on 04/06/16 at 4:30 PM, revealed she was the nurse who had assessed Resident #4 after the fall in the West Wing Shower Room on 01/20/16. When she entered the shower room she saw Resident #4 laying on the shower floor in front of the shower chair, face down with both arms under him/her. She stated the aide told her he/she had turned around from the resident and the resident attempted an unassisted transfer from the shower chair. The Nurse Aide care plans were updated with changes and the aides were to follow the care plans. She stated the nurse who had completed the admission paperwork would have initiated the interim care plan using the information from the hospital and the nursing assessment. LPN #11 stated she could not recall what the interim care plan or the nurse aide care plan said. She recalled the resident was to be transferred with a physical assist of one (1) or two (2) persons, but after the fall, the resident was a total assist. The facility took the following actions to remove the Immediate Jeopardy: 1. On 03/14/16, Director of Nursing (DON) #3 removed the stakeholder (Unlicensed Graduate Nurse), who did not have a provisional, from the LPNA role. On 03/28/16, the Administrator suspended the stakeholder. 2. The Corporate Care Consultants reviewed and validated thirty-one (31) stakeholders working as licensed nurses on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) 03/28/16; and, seven (7) were validated on 04/01/16 via the Kentucky Board of Nursing (KBN) online verification report. No stakeholder was found to be working without a valid nursing license. 3. The Corporate Care Consultants reviewed all current residents medical records that were assigned to the non-licensed stakeholder. Forty-one (41) charts were reviewed on 03/31/16; and, nine (9) were reviewed on 04/01/16. Of the fifty (50) charts reviewed, no care issues were noted related to the non-licensed stakeholder. The facility identified twenty-one (21) clinical records that had missing credentials. The DON and Nurse Managers began education addressing appropriate signage of the medical record including credentials for the unlicensed nurse. The facility implemented a Medical Record Review Process on 04/04/16 by the DON. The DON and/or Nurse Managers would review the medical record (physician's orders [REDACTED]. Five (5) percent of the current census would be reviewed for physician orders, nurses' notes and assessments in the daily clinical meeting (Monday-Friday) for two (2) weeks; if compliance was maintained, audits would decrease to 5% three (3) times a week for four (4) weeks, and then monthly for three (3) months. 4. The Consultants provided education to the DON and Nurse Managers on 04/01/16, on the process of auditing of the medical record(s). The education consisted of: legible signature to include credentials; physician orders [REDACTED]. The Nurse Managers, Staff Developed Coordinator (SDC), and DON #3 provided the above education to all licensed nursing stakeholders 04/01/16 through 04/04/16. Any licensed stakeholder that had not received the education by 04/04/16 would be issued a certified letter with the training material. Education and Post Education Competency would be completed by the DON and/or Nurse Managers in person and/or via phone for licensed nurses from 04/01/16 through 04/04/16. When conducting the Post Education Competency via phone, the SDC and/or Nurse Managers would ask the examination questions and document the licensed nurse's response on the examination. The SDC and/or Nurse Managers would follow up with the nurse in person to go over the training material verbally and the stakeholder would complete a written examination with the stakeholder's signature. The SDC and/or Nurse Managers would provide the training to a new stakeholder through the orientation program. The SDC and/or Nurse Manager would provide the Administrator and DON with a verbal progress report of the new stakeholder's performance and/or education skills needed during the orientation process. 5. The Human Resources (HR) Personnel, Receptionist, or Nurse Managers would conduct a KBN online validation report during the interview process for stakeholders applying for a licensed position and when a licensed position status change had occurred. The validation would be printed, reviewed, and signed by the DON, HR Personnel, Receptionist, or Nurse Manager as proof of validation status. The Administrator would conduct the final review. The HR Personnel, Receptionist, or Nurse Managers would conduct monthly and/or needed licensure review via KBN online validation report to ensure licenses were valid for three (3) months. If compliance is maintained, audits would be reduced to quarterly for two (2) quarters then annually thereafter. The Corporate Care Consultants would review completed KBN online validation reports daily (Monday-Friday) for four (4) weeks. If compliance is maintained, audits would decrease to two (2) times per week for four (4) weeks to ensure the validation process was completed. The audits would decrease to monthly for three (3) months during their facility visits. 6. The Corporate Care Consultants, Regional Vice President, and/or HR Advisory Personnel would provide ongoing education as needed for new administrative staff. The consultants would provide facility visits a minimum of five (5) days per week for two (2) weeks to review action plan and assist with education needs. If compliance was maintained, the visits would decrease to three (3) per week for eight (8) weeks, then a minimum of monthly thereafter. 7. An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 03/28/16 to review the survey findings and the facility's licensure validation process. Those in attendance included the Administrator, DON, HR Director, Unit Nurse Managers, and the Medical Director. On 03/30/16, a second Ad Hoc QAPI meeting was conducted with the Administrator, DON, Medical Director, Social Services, SDC, and Unit Managers to review policies and procedures related to the hiring and orientation process, and the supervision of LPNAs, RNAs, and student nurses. No changes were made to the hiring process or the Orientation Checklist. The Orientation Checklist for licensed stakeholders would be utilized for LPNAs and RNAs with direct supervision. A new Supervision Policy was created for LPNAs, RNAs, and student nurses on 03/30/16 during the QAPI meeting with the approval of the Medical Director. In addition, the Physical Order/Supplies and Scheduling of Medical Appointments Process was reviewed with no changes. A third Ad Hoc meeting was held on 04/01/16 with the Administrator, DON, and Medical Director via phone to review all recent survey citations and action plans. On 04/04/16, the Administrator and DON met with the Medical Director for overview of the survey findings: F281-discussed the incident with a non-licensed nurse related to Professional Standards with implementation of Licensure Validation Process; F282-discussion of oversight to ensure the care plan was followed; F309-discussed the failure to follow physician orders, provision of supplies, and scheduling of medical appointments; F490-reviewed the role of the Administrator to provide oversight for facility operations. Guidance and oversight would be provided by the Regional Vice President. The Administrator would review all audits and conduct observation rounds. F499- recapped the process for preventing non-licensed staff from working as licensed staff by completing the Licensure Validation Process. F514-reviewed education provided to maintain compliance in the deficient areas, including a post examination. Al
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, it was determined the facility failed to ensure staff followed the care plan in regards to physician ordered appointments (Wound Care Clinic) for one (1) of twelve (12) sampled residents (Resident #5). An Unlicensed Graduate Nurse, who was not working under a Preceptor at the time, and did not have a provisional license, failed to put the weekly appointment for Resident #5's wound care on the appointment calendar, thus causing Resident #5 to miss at least two (2) appointments, one on 02/04/16; and, another one on 02/18/16. The facility failed to have an effective system in place to ensure staff followed the plans of care for residents, placing residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/30/16 and determined to exist on 11/30/15. The facility was notified of the Immediate Jeopardy (IJ) on 03/30/16. The facility provided an acceptable Allegation of Compliance (AOC) on 04/04/16, which alleged removal of the (IJ) on 04/05/16. The State Survey Agency (SSA) verified the IJ was not removed on 04/05/16, as alleged, but on 04/07/16 (facility allowed a nurse to return to work without training on 04/06/16) prior to exit on 04/08/16. The Scope and Severity (S/S) was lowered to a D while the facility develops and implements the plan of correction and the Quality Assurance (QA) monitors for effectiveness of the systemic changes. The findings include: Review of the facility's Care Plan Policy, not dated, revealed the facility would incorporate goals and objectives that would lead to the resident's highest obtainable level of independence. Review of Resident #5's closed record, revealed the facility admitted the resident on 02/03/16, with [DIAGNOSES REDACTED]. Review of Resident #5's Comprehensive Care Plan; for Impaired Skin Integrity, dated 02/04/16, revealed Resident #5 was to follow up with the Wound Clinic as ordered. Review of Resident #5's Physician Orders, dated 02/03/16, revealed Resident #5 was ordered to go to the Wound Clinic every Thursday to change the wound V.A.C. (Vacuum Assisted Closure) which was a NPWT (Negative-pressure Wound Therapy). Review of the February 2016 Appointment Calendar, revealed on 02/11/16 Resident #5 was to go to the Wound Clinic for wound V.A.C. treatment, but was sent to the emergency room for chest pain. However, the resident had a physician's orders [REDACTED].#5. Interview with the Wound Clinic Manager, on 03/17/16 at 11:02 AM, revealed Resident #5 had orders to come to the Wound Clinic on Thursdays, but Resident #5 had not come for his/her appointment a single time. Interview with Medical Records staff, on 03/17/16 at 5:48 PM, revealed she was responsible for scheduling resident appointments. Further interview revealed she had only set up an appointment for 02/11/16 for Resident #5 to be seen at the wound clinic. According to the Medical Records' staff, no one had voiced to her that Resident #5 was to have an appointment scheduled for every Thursday with the Wound Clinic. Interview with the Unlicensed Graduate Nurse, on 03/17/16 at 3:21 PM, revealed the nursing staff completed the initial care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 11)

plan. Further interview revealed the care plan for Resident #5 stated the resident was to go to the Wound Clinic as ordered. The Unlicensed Graduate Nurse stated she did not know Resident #5 was not transported to his/her Wound Clinic Appointment, and it appeared the staff was not following the care plan as directed. She stated she was the Admission Nurse for Resident #5 and was responsible for the completion of all aspects of an admission, which would include placing appointments on the calendar. Further interview at 5:28 PM, revealed she was ultimately responsible to ensure Resident #5's appointments were on the Appointment Calendar because she signed that the order was taken off, and staff was expected to follow the physician's orders [REDACTED].

Interview with Unit Manager #1 (Manager on the West Hall), on 03/17/16 at 4:33 PM, revealed the care plan was not followed for Resident #5 as it pertained to the resident going to the wound clinic on Thursdays. The Unit Manager stated the staff was expected to follow the care plan.

Interview with the Minimum Data Set (MDS) Coordinator, on 03/17/16 at 5:44 PM, revealed Resident #5's family had informed her that Resident #5 was to go to the wound clinic on Thursdays during her initial assessment. According to the MDS Coordinator, the nurses completed the initial care plan and MDS Coordinator completed the comprehensive care plan. The MDS Coordinator stated she expected the staff to follow the care plan.

Interview with the current Director of Nursing (DON) #3, on 03/17/16 at 5:50 PM, revealed upon admission, the nurses completed the initial care plan and the MDS Coordinators completed the comprehensive care plan. The DON stated the nursing staff was not following the care plan if they had not ensured Resident #5 got to his/her Wound Clinic appointment.

The facility implemented the following actions to remove the Immediate Jeopardy:

1. On 03/14/16, Director of Nursing (DON) #3 removed the stakeholder (Unlicensed Graduate Nurse), who did not have a provisional, from the LPNA role. On 03/28/16, the Administrator suspended the stakeholder.

2. The Corporate Care Consultants reviewed and validated thirty-one (31) stakeholders working as licensed nurses on 03/28/16; and, seven (7) were validated on 04/01/16 via the Kentucky Board of Nursing (KBN) online verification report. No stakeholder was found to be working without a valid nursing license.

3. The Corporate Care Consultants reviewed all current residents medical records that were assigned to the non-licensed stakeholder. Forty-one (41) charts were reviewed on 03/31/16; and, nine (9) were reviewed on 04/01/16. Of the fifty (50) charts reviewed, no care issues were noted related to the non-licensed stakeholder. The facility identified twenty-one (21) clinical records that had missing credentials. The DON and Nurse Managers began education addressing appropriate signage of the medical record including credentials for the unlicensed nurse.

The facility implemented a Medical Record Review Process on 04/04/16 by the DON. The DON and/or Nurse Managers would review
the medical record (physician's orders [REDACTED].

Five (5) percent of the current census would be reviewed for physician orders, nurses' notes and assessments in the daily clinical meeting (Monday-Friday) for two (2) weeks; if compliance was maintained, audits would decrease to 5% three (3) times a week for four (4) weeks, and then monthly for three (3) months.

4. The Consultants provided education to the DON and Nurse Managers on 04/01/16, on the process of auditing of the medical record(s). The education consisted of: legible signature to include credentials; physician orders [REDACTED].

The Nurse Managers, Staff Developed Coordinator (SDC), and DON #3 provided the above education to all licensed nursing stakeholders 04/01/16 through 04/04/16.

Any licensed stakeholder that had not received the education by 04/04/16 would be issued a certified letter with the training material. Education and Post Education Competency would be completed by the DON and/or Nurse Managers in person and/or via phone for licensed nurses from 04/01/16 through 04/04/16. When conducting the Post Education Competency via phone, the SDC and/or Nurse Managers would ask the examination questions and document the licensed nurse's response on the examination. The SDC and/or Nurse Managers would follow up with the nurse in person to go over the training material verbally and the stakeholder would complete a written examination with the stakeholder's signature. The SDC and/or Nurse Managers would provide the training to a new stakeholder through the orientation program. The SDC and/or Nurse Manager would provide the Administrator and DON with a verbal progress report of the new stakeholder's performance and/or education skills needed during the orientation process.

5. The Human Resources (HR) Personnel, Receptionist, or Nurse Managers would conduct a KBN online validation report during the interview process for stakeholders applying for a licensed position and when a licensed position status change had occurred. The validation would be printed, reviewed, and signed by the DON, HR Personnel, Receptionist, or Nurse Manager as proof of validation status. The Administrator would conduct the final review.

The HR Personnel, Receptionist, or Nurse Managers would conduct monthly and/or needed licensure review via KBN online validation report to ensure licenses were valid for three (3) months. If compliance is maintained, audits would be reduced to quarterly for two (2) quarters then annually thereafter.

The Corporate Care Consultants would review completed KBN online validation reports daily (Monday-Friday) for four (4) weeks. If compliance is maintained, audits would decrease to two (2) times per week for four (4) weeks to ensure the validation process was completed. The audits would decrease to monthly for three (3) months during their facility visits.

6. The Corporate Care Consultants, Regional Vice President, and/or HR Advisory Personnel would provide ongoing education as needed for new administrative staff. The consultants would provide facility visits a minimum of five (5) days per week for two (2) weeks to review action plan and assist with education needs. If compliance was maintained, the visits would decrease to three (3) per week for eight (8) weeks, then a minimum of monthly thereafter.

7. An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 03/28/16 to review the survey findings and the facility's licensure validation process. Those in attendance included the Administrator, DON, HR Director, Unit Nurse Managers, and the Medical Director.

On 03/30/16, a second Ad Hoc QAPI meeting was conducted with the Administrator, DON, Medical Director, Social Services, SDC, and Unit Managers to review policies and procedures related to the hiring and orientation process, and the supervision of LPNAs, RNAs, and student nurses. No changes were made to the hiring process or the Orientation Checklist. The Orientation Checklist for licensed stakeholders would be utilized for LPNAs and RNAs with direct supervision. A new Supervision Policy was created for LPNAs, RNAs, and student nurses on 03/30/16 during the QAPI meeting with the approval of the Medical Director. In addition, the Physical Order/Supplies and Scheduling of Medical Appointments Process was reviewed with no changes.

A third Ad Hoc meeting was held on 04/01/16 with the Administrator, DON, and Medical Director via phone to review all recent survey citations and action plans.

On 04/04/16, the Administrator and DON met with the Medical Director for overview of the survey findings: F281-discussed the incident with a non-licensed nurse related to Professional Standards with implementation of Licensure Validation Process; F282-discussion of oversight to ensure the care plan was followed; F309-discussed the failure to follow physician orders, provision of supplies, and scheduling of medical appointments; F490-reviewed the role of the Administrator to provide oversight for facility operations. Guidance and oversight would be provided by the Regional Vice President. The Administrator would review all audits and conduct observation rounds. F499- recapped the process for preventing non-licensed staff from working as licensed staff by completing the Licensure Validation Process. F514-reviewed education provided to maintain compliance in the deficient areas, including a post examination. Also reviewed the audit system/tools implemented to monitor processes. Audits would be discussed in the morning meeting, weekly QAPI and monthly QAPI.

The IDT team will meet weekly times four (4) weeks to review all audit findings. If compliance was maintained, will reduce to monthly.

8. Order/Supply Process: Licensed nurse (s) would place physician orders [REDACTED]. Medical appointments would be scheduled as ordered, including transportation and logged on the monthly calendar. Unit Managers (Nurse Mangers) would review admission/readmission and/or new telephone orders and discuss in the morning clinical meetings (Monday-Friday). Ordered supplies would be discussed in the morning clinical meeting to ensure supplies were available for the resident (s). If the supplies cannot be obtained, a licensed nurse would contact the resident's physician for alternative orders until the supplies were available.

9. The Regional Vice President reviewed administrative duties that included: hiring process, licensure validation, facility oversight, role of the Administrator-in-training, and the job description with the Administrator on 04/04/16. The Regional Vice President will conduct weekly telephone calls with the Administrator for four (4) weeks to discuss current action

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 12) plans and audit findings. If the facility's operations and oversight meet the residents' needs, the conference call would decrease to monthly for three (3) months, and then quarterly thereafter. If non-compliance is noted, the Vice President would modify oversight as needed to meet the needs of the residents. The State Agency validated removal of the Immediate Jeopardy on 04/07/16 as follows: 1. Review of the Stakeholder Suspension Form revealed the unlicensed stakeholder was suspended on 03/28/16 by the Administrator. Review of a written statement from DON #3 revealed she removed the employee from any licensed nurse duties on 03/14/16. Interview with the DON, on 04/06/16 at 3:29 PM and Administrator, on 04/06/16 at 5:03 PM, validated the stakeholder was suspended on 03/28/16. 2. Review of the facility's licensed staff roster revealed thirty-eight (38) nurses were employed as of 04/06/16. All thirty-eight (38) nurses had a KBN validation report validating they had a valid nursing license. Interview with Corporate Care Consultants #2, and #3, on 04/07/16 at 1:03 AM, revealed the facility had obtained validation of license for all nurses employed by the facility. Received validation reports from the KBN and no stakeholder was working without a license. 3. Review of the medical record review audit sheet revealed forty-three (43) records were reviewed with no problem identified. The audits were conducted on 03/31/16 and 04/01/16 by three (3) Corporate Care Consultants. Interview with Corporate Care Consultants #2 and #3, on 04/07/16 at 10:03 AM, revealed the review of the clinical record found no resident experienced a negative outcome related to the non-licensed stakeholder. The audit did find the nurses were not always signing with credentials. Review of the Medical Record Audit sheets, dated 04/01/16 through 04/06/16, revealed eight (8) to ten (10) residents' records were audited daily by the DON, Nurse Managers, and Corporate Care Consultants. Interview with Consultants #2 and #3, on 04/07/16 at 10:03 AM, West Wing Unit Manager, on 04/06/16 at 3:10 PM, and DON #3, on 04/06/16 at 3:29 PM, revealed medical record audits were being conducted for 5% of the resident census to ensure physician orders [REDACTED]. 4. Review of the training records revealed DON #3, East Unit Manager and West Unit Manager revealed they received training on 04/01/16 on how to audit the medical record and education on legible signatures with credentials, physician orders, supervision of LPNAs, RNAs, and nursing students, following care plans, and scheduling appointments. A post test was taken with the DON and managers scoring 100%. Interview with DON #3, on 04/06/16 at 3:29 PM, revealed she had received the education on the topic above. She then provided training to all licensed nursing stakeholders. She was trained on how to conduct the medical record audits and was involved in conducting those audits. Interview with the East Wing Unit Manager, on 04/06/16 at 11:25 AM, revealed she had been trained to do the medical record audits; however, she had not conducted the audits to date. She revealed she had only been in this position for three (3) weeks and was still learning. Further interview revealed she validated she had received training on physician orders, care plans, scheduling of appointments, documentation to be legible and to include credentials; and, supervision of LPNAs and RNAs. She had not conducted training of the nurses. Interview with the West Wing Unit Manager, on 04/06/16 at 3:10 PM, revealed she had been trained on how to conduct audits of the medical record and had conducted a few over the weekend. She validated she received training on physician orders, documentation in the medical record to be legible with credentials, care plans, scheduling of appointments, physician orders, and supervision of LPNAs and RNAs. She had not conducted training of the nurses. Review of the training records and post test revealed thirty-three (33) licensed nurses and four (4) Certified Medication Technicians were trained on documentation in the medical record that was complete, legible and included credentials. In addition, physician orders, care plans, scheduled appointments, and supervision of LPNAs and RNAs was also reviewed by the survey team. All had passed the post test with a score of 100. Record review revealed five (5) stakeholders had not received the training as of 04/04/16. Certified letters were sent on 04/04/16 to those employees. Copies of the letters were reviewed and the certified mail receipts. A letter written by the Administrator, dated 04/04/16, accompanied the training material. In the letter, the Administrator instructed the licensed nurses they must review the enclosed education material and complete a post test before returning to work. The stakeholder was instructed to turn in the post test and sign the training roster before returning to the facility for a scheduled shift. Validation interviews were conducted on 04/06/16 with LPN #12 at 10:46 AM, LPN #9 at 11:08 AM, LPN #6 at 1:46 PM, LPN #11 at 4:23 PM, and LPN #3 at 4:38 PM, revealed they had received the training and taken the post test. Each nurse had good knowledge of the training topics. Interview with LPN #8, on 04/06/16 at 11:42 AM revealed she needed to complete the training. She stated she had been informed of a certified letter, but she had not been to the post office to pick up the certified letter. Therefore, she did not know what the letter contained. She stated she started her work shift today at 6:30 AM and nobody had informed her that she had to complete the training before caring for residents. She stated the Unit Manager had not said anything to her and she had not received any training over the phone. Interview with the West Unit Manager, on 04/16/16 at 11:58 AM, revealed she was unaware the nurse had not received the training. She stated she did realize the DON had not provided training over the phone until the nurse could receive the training in person and taken the post test. Interview with DON #3, on 04/06/16 at 12:06 AM and 12:12 PM, revealed she had called LPN #8 twice and never could reach her. She assumed the nurse had received the certified letter with the training material. She stated she had reviewed the working schedule and didn't realize the nurse was working (that day). She stated it was an oversight and she or the Unit Manager realized she had not been trained. Verification of the nurse's training with a post test was provided to the surveyor on 04/16/16 at 12:10 PM. 5. Review of a newly hired nurse, on 03/29/16, validation check revealed the facility conducted a KBN online validation report on 03/29/16 that revealed the nurse had a valid license. The validation report was reviewed by the HR Personnel, DON #3, Administrator, and Corporate Consultant as indicated by their signatures on the validation report. Review of the training revealed the newly hired nurse had received education on the topics that were included in the AOC. Interview with the HR Director, on 04/06/16 at 4:05 PM, revealed she had received training on the validation process. She stated once an application was received and before an offer letter was sent, she would conduct a validation check with the KBN. After the offer letter was sent another check was conducted at the KBN for abuse registry and a Criminal Background Check would be conducted. She stated she would review the validation report from the KBN then the DON, and the Administrator would do the final check. She stated she assisted with the validation of license for the facility's nurses. The Corporate Consultant signed off as reviewing the hire packet for the newly hired nurse on 04/01/16. The consultant reviewed and signed off on the nurses who are in the interviewing process. 6. Interview with Corporate Care Consultants #2 and #3 and the Special Project Consultant, on 04/07/16 at 10:03 AM revealed they would be providing oversight and assistance to the facility for some time. They stated they have been at the facility daily including some weekend days to conduct audits and assist with educational needs. Consultants #1, #2, and #3 would be at the facility Monday-Friday for several weeks to review action plans, audits, and training before they decrease to three (3) times a week. Once they identify any non-compliance, re-education would be conducted. They were looking at the clinical matrix, and the development of education topics that may include other disciplines beside nursing. The facility did not have a new Administrator in training at the time of the survey. A consultant will attend the clinical meetings to ensure a meeting is held as stated and topics discussed. The consultants reviewed the audits to ensure they were being conducted correctly and to see if there were any training issues. They were in the process of developing an afternoon meeting to recap the day. 7. Review of the QAPI signature sheet, dated 03/28/16, revealed the survey findings were discussed. The Medical Director, Administrator, DON, Corporate Consultant #1, and five (5) other committee members. On 03/30/16, an Ad Hoc meeting was held to discuss the Immediate Jeopardy findings. The Administrator, DON, Unit Managers and SDC was present with the Medical Director via phone conference. Additional Ad Hoc QAPI meetings were held on 04/01/16, 04/04/16 and 04/06/16. Interview with the Administrator, on 04/06/16 at 5:03 PM, validated the above QAPI meetings were held. She stated she conducted the meetings and the Medical Director was either present in person or via phone. She stated the frequent QAPI meetings were to review what process had been changed and were they effective. The committee reviewed the audits. She stated the audits were also reviewed in the morning meetings before they were reviewed in the QAPI meetings. She stated she will conduct a weekly QAPI meeting for the next month. In addition, the IDT meet weekly to review the audits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**	

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 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) Interview with the Medical Director, on 04/06/16 at 4:48 PM, revealed he had been involved in the whole process since the beginning of the Immediate Jeopardy. The facility's Administrator provided him an overview of the survey findings and requested his input in the corrective plans. He reviewed the policies and validation process and discussed the physician orders [REDACTED]. 8. Review of Unsampled Residents L's and M's record revealed physician orders [REDACTED]. Review of the appointment calendar revealed the scheduled appointment had been placed in the calendar with transportation obtained. Review of the appointment calendars for the East and West Units and audits revealed no missed appointments. 9. Review of the education provided by the Regional Vice President to the Administrator and DON #3, on 04/04/16, revealed the training was on F490 and review of the Administrator's job description. A telephone interview with the Regional Vice President, on 04/07/16 at 9:54 AM, revealed he validated the training provided to the facility's Administrator. He stated he reviewed the role of the Administrator and responsibilities related to the hiring process, licensure validation, facility oversight, and Administrator in training. He stated the Administrator would provide oversight through observation rounds and review of clinical meeting findings. He stated he would conduct weekly telephone conference calls with the Administrator to discuss current corrective action plans, audit findings, facility operation, and oversight met the residents' needs. He would conduct the weekly calls for four (4) weeks and then decrease to monthly times three (3) months, then quarterly.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, it was determined the facility failed to follow the Physician's Orders for one (1) of twelve (12) sampled residents (Resident #5). On 02/16/16, student nurses were in the facility for clinical instruction and were completing the treatments. The student nurse instructor packed Resident #5's wound with Kerlix without a physician's order when there was not enough supplies to properly apply a wound V.A.C. (Vacuum Assisted Closure) which is a NPWT (Negative-pressure Wound Therapy) as ordered to Resident #5's left groin wound. However, the Advanced Practice Registered Nurse (APRN) removed two (2) feet of Kerlix from Resident #5's abdomen on 02/19/16 and notified the physician on that date. In addition, the Unlicensed Graduate Nurse failed to place appointment dates on the calendar for 02/04/16 and 02/18/16 to ensure Resident #5 went to his/her Wound Clinic appointment every Thursday as ordered. Resident #5 missed both appointments and the wound was not evaluated at the wound clinic by the physician. The facility's failure to have an effective system in place to ensure residents received wound treatments and wound appointments as ordered by the physician placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/30/16 and determined to exist on 11/30/15. The facility was notified on the Immediate Jeopardy on 03/30/16. The facility provided an acceptable Allegation of Compliance (AOC) on 04/04/16, which alleged removal of Immediate Jeopardy on 04/05/16. The State Survey Agency (SSA) verified the Immediate Jeopardy was not removed on 04/05/16 as alleged, but on 04/07/16 (facility allowed a nurse to return to work without training on 04/06/16) prior to exit on 04/08/16. The Scope and Severity was lowered to a D while the facility develops and implements a Plan of Correction and the Quality Assurance monitors for effectiveness of the systemic changes. The findings include: Review of the Physician's Orders Policy, last reviewed 06/01/15, revealed no documentation, as it pertained to the nursing staff following the physicians' orders. Interview with the Nurse Consultant, on 03/30/16 at 4:42 PM, revealed the facility did not have a policy regarding Student Nurses and/or Unlicensed Graduate Nurses working in the facility. 1. Review of Resident #5's closed record, revealed the facility admitted Resident #5 on 02/03/16 with [DIAGNOSES REDACTED]. Review of Resident #5's Physician's Orders, dated 02/03/16, revealed Resident #5 had an order to have a wound V.A.C. to the left groin. Interview with the facility's Wound Nurse, on 03/16/16 at 5:24 PM, revealed she changed Resident #5's Kerlix dressing to the wound V.A.C. the day he/she was admitted on [DATE]. The Wound Nurse stated there were supplies that came with the resident from the hospital such as a black/gray sponge, drapes and canisters to complete the treatment. However, on 02/16/16 the Nursing Instructor only found a small oval shaped sponge approximately six (6) inches. It was determined there was not enough supplies to complete future treatments and she did not think to request more supplies. According to the Wound Nurse, after she changed the initial dressing, she did not change any more of Resident #5's dressings because the dressing would have been changed on 02/04/16 at the wound clinic. The Wound Nurse just monitored the drainage that was coming from the wound V.A.C. Interview with Licensed Practical Nurse (LPN) #4, on 03/17/16 at 9:08 AM, revealed on 02/16/16 (Tuesday), nursing students were in the facility and were completing treatments. According to LPN #4 the Nursing Instructor informed her they did not have all the supplies they needed. LPN #4 then called the Wound Nurse to inform her that the Nursing Instructor said she could use gauze/Kerlix and place the smaller black sponge on top. LPN #4 stated the wound nurse said that would be fine. According to LPN #4, she then called the wound V.A.C. company to inform them the facility was in need of supplies. Further interview with LPN #4 revealed she did not call the Physician to obtain new orders for the use of the gauze/Kerlix that the Nursing Instructor applied to Resident #5's surgical wound. Interview with the Wound Nurse, on 03/17/16 at 3:59 PM, revealed LPN #4 had mentioned the use of Kerlix on Resident #5's abdominal wound and she told LPN #4 that the Nursing Instructor could not use Kerlix on Resident #5's surgical wound. The Wound Nurse stated LPN #4 should have notified her, the Director of Nursing (DON) or the Unit Secretary if she had run out of supplies for Resident #5's wound V.A.C. Review of Resident #5's Physician's Orders revealed no new orders were in place for packing gauze or Kerlix in the resident's surgical wound on 02/16/16. Interview with LPN #1, on 03/17/16 at 2:51 PM, revealed she worked on Friday 02/19/16 and remembered receiving report from the Unit Manager who had worked the night shift. The Unit Manager informed her there had not been any wound V.A.C. supplies for three (3) days, since Tuesday 02/16/16. The Unit Manager informed her that the supplies were coming as soon as possible and to expect the supplies to come in that day. Interview with the Unit Secretary, on 03/17/16 at 3:54 PM, revealed she called the wound V.A.C. vendor to re-order supplies. The vendor stated they would send the supplies the next day. The Unit Secretary could not remember which day she called to order the supplies, nor could she remember which nurse requested the supplies be ordered. Further interview with LPN #1, on 03/17/16 at 2:51 PM, revealed when the supplies came in she and the Advanced Practical Registered Nurse (APRN) changed the dressing to Resident #5's abdomen. LPN #1 stated she remembered removing a black sponge and tube and then irrigated the wound. She stated she then saw this white thing and when she grabbed it she discovered it was Kerlix. LPN #1 stated it was hard to pull out. According to LPN #1, the Treatment Administrative Record (TAR), did not say to pack the surgical wound with Kerlix and if they did not have supplies, Resident #5's wound could become infected and make the resident become septic. LPN #1 further stated the nursing staff was expected to follow the Physician's Orders. Interview with the Advanced Practical Registered Nurse (APRN), on 03/16/16 at 3:05 PM, revealed she assisted LPN #1 with Resident #5's wound V.A.C. on 02/19/16. She stated she heard the nurse say they had run out of supplies for the wound V.A.C. and the supplies had just arrived. According to the APRN, Resident #5's wound had some tunneling and it was deep. The APRN removed the black foam and began to flush the dressing. The APRN then saw some white stuff, after pulling it out there was two (2) feet of Kerlix tucked into Resident #5's abdomen. The APRN called Doctor #1 (the attending) and informed him that Resident #5's wound was tunneling and deep. Doctor #1 agreed with her to change the order from the wound V.A.C. to wet to dry dressings so that the wound would heal from the inside out. The APRN stated the hospital had not reported the wound was tunneling. Record review revealed there was no hospital documentation that stated the wound was tunneling. Further interview with the APRN, on 03/17/16 at 5:10 PM, revealed the instructor should not have placed the Kerlix in Resident #5's wound. She stated no one called to ask to change the order from the wound V.A.C. to a wet to dry dressing. The APRN stated she expected the staff to follow physician orders. Interview with the Staff Development Coordinator (SDC), on 03/30/16 at 8:55 AM, revealed there was no oversight provided for the clinical students. Their Clinical Instructor was their oversight. The SDC stated the Clinical Instructors just asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185180		**04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) her when they could come to the facility and she would then ask the Director of Nursing for approval. 2. Review of Resident #5's admission Physician Orders, dated 02/03/16, revealed the nursing staff was to change Resident #5's wound V.A.C. on Tuesday and Saturday; and, the Wound Clinic was to change the wound V.A.C. every Thursday. Review of Resident #5's Treatment Administration Record (TAR) for the month of February 2016, revealed the only day that was signed for the resident to attend the wound clinic was on Thursday, 02/11/16. Review of the February 2016 Appointment Calendar, revealed the resident was to go to [MEDICAL TREATMENT] on Monday, Wednesday and Friday; and, on 02/11/16, Resident #5 was to go to the Wound Clinic for treatment. Resident #5 should have been scheduled to go to the Wound Clinic on 02/04/16 and 02/18/16 (Thursdays after admission). However, review of the Appointment Calendar revealed Resident #5 was not scheduled to go to the Wound Clinic on 02/04/16 and 02/18/16. Interview with the Unlicensed Graduate Nurse, on 03/17/16 at 3:21 PM, revealed she was the admission nurse for Resident #5 and was responsible for the completion of all aspects of an admission. Placing appointments on the calendar would have been one of the admission duties. Further interview with the Unlicensed Graduate Nurse, on 03/17/16 at 5:28 PM, revealed she was ultimately responsible to ensure Resident #5's appointment was on the Appointment Calendar because she signed that the order was taken off, and staff was expected to follow the physician orders. However, she did not add the appointment dates to the calendar. According to the Unlicensed Graduate Nurse, if something was not documented then the task was not done. Interview with LPN #7, on 03/29/15 at 1:45 PM, revealed when admitting a new resident to the facility the nurse hand writes the orders onto the Medication Administration Record [REDACTED]. The nurse calls the doctor to verify the orders and a second nurse checks the MARs and TARS for accuracy. Interview with the Unit Secretary, on 03/17/16 at 5:42 PM, revealed she did not set up appointments or place the appointments on the Appointment Calendar. The Unit Secretary stated Medical Records was responsible to complete this task. According to the Unit Secretary, the nursing staff usually left a note for Medical Records to inform her of the appointment and she did not remember an order for [REDACTED]. Interview with Medical Records, on 03/17/16 at 5:48 PM, revealed she was responsible to set up the resident appointments. According to Medical Records she only set up an appointment for 02/11/16. Medical Records said no one had voiced to her that the appointment had to be scheduled for every Thursday with the Wound clinic. Interview with the Unit Manager, on 03/17/16 at 4:33 PM, revealed Resident #5's Wound Clinic appointment was supposed to be documented on the Appointment Calendar and the only appointment documented for Resident #5 was the one scheduled on 02/11/16. According to the Unit Manager, the nurse should have placed the appointment on the Appointment Calendar for every Thursday as ordered. If Resident #5 did not attend his/her appointment, the nursing staff should document the reason why the resident did not attend the appointment. The Unit Manager stated the staff was responsible for following physician's orders. Review of Resident #5's Nursing Notes, revealed no evidence as to why Resident #5 did not attend the 02/04/16 and 02/18/16 Wound Clinic appointments. Interview with the current Director of Nursing, (DON) #3, on 03/17/16 at 5:31 PM, revealed the nursing staff should have verified the appointment with the Wound Clinic and placed it on the Appointment Calendar where schedules were documented. The nursing staff should have asked the resident if his/her family was taking them to the appointment or if the resident would need other transportation provided. According to the DON, usually the Unit Secretary placed the appointments on the Calendar and the Unit Manager would look at the admission's information to verify that the orders were taken off correctly. Interview with the Wound Clinic Manager, on 03/17/16 at 11:02 AM, revealed Resident #5 was ordered to come to the Wound Clinic on Thursdays, but had not come a single time. The Manager stated there were conversations with the facility about the resident not feeling well or that no family was available to interpret because the resident spoke a different language. According to the Wound Clinic Manager, the goal was for Resident #5 to have the wound V.A.C., changed three (3) times a week, two (2) times at the facility and once (1) at the Wound Clinic for Doctor #2 (the wound care doctor) to see. Interview with Doctor #2, on 03/17/16 at 11:20 AM, revealed she saw Resident #5 briefly on 02/11/16 in the emergency room when Resident #5 was seen for chest pain. Doctor #2 stated the wound was dressed as ordered and looked good. According to Doctor #2, the reason she ordered the Wound V.A.C. was because the surgical wound was large and when you looked at the surface the surgical wound had an opening, underneath the abdominal wall, the distance and length longer than the hand. Doctor #2 was observed to hold her forearm the length of the surgical wound. Doctor #2 stated the wound V.A.C. was known to heal the wounds quicker. She stated the wound was not tunneling; however, it was more like a cavern. She stated when she saw Resident #5, on 02/25/16, his/her wound had a small pocket trying to form. She utilized her finger to open the wound and was able to place the wound V.A.C. in the wound without difficulty. Interview with DON #3, on 03/28/16 at 12:03 PM, revealed when she found out the Unlicensed Graduate Nurse did not have a provisional license, she was confused. DON #3 stated she then had concerns that the Unlicensed Graduate Nurse was working on the Rehabilitation Unit. The DON stated some of the things that occurred to Resident #5 could have been prevented. There should have been a licensed nurse doing the admission for Resident #5. DON #3 stated to her knowledge there was no evidence that a nurse had documented behind her to ensure they monitored the care the Unlicensed Graduate Nurse provided. The facility took the following actions to remove the Immediate Jeopardy: 1. On 03/14/16, DON #3 removed the stakeholder (Unlicensed Graduate Nurse), who did not have a provisional, from the LPNA role. On 03/28/16, the Administrator suspended the stakeholder. 2. The Corporate Care Consultants reviewed and validated thirty-one (31) stakeholders working as licensed nurses on 03/28/16; and, seven (7) were validated on 04/01/16 via the Kentucky Board of Nursing (KBN) online verification report. No stakeholder was found to be working without a valid nursing license. 3. The Corporate Care Consultants reviewed all current residents medical records that were assigned to the non-licensed stakeholder. Forty-one (41) charts were reviewed on 03/31/16; and, nine (9) were reviewed on 04/01/16. Of the fifty (50) charts reviewed, no care issues were noted related to the non-licensed stakeholder. The facility identified twenty-one (21) clinical records that had missing credentials. The DON and Nurse Managers began education addressing appropriate signage of the medical record including credentials for the unlicensed nursee. The facility implemented a Medical Record Review Process on 04/04/16 by the DON. The DON and/or Nurse Managers would review the medical record (Physician's Orders, Nurse's Notes, assessments, etc) to ensure appropriate signage including credentials was completed by the licensed nurse. Five (5) percent of the current census would be reviewed for physician orders, nurses's notes and assessments in the daily clinical meeting (Monday-Friday) for two (2) weeks; if compliance was maintained, audits would decrease to 5% three (3) times a week for four (4) weeks, and then monthly for three (3) months. 4. The Consultants provided education to the DON and Nurse Managers on 04/01/16, on the process of auditing of the medical record(s). The education consisted of: legible signature to include credentials; physician orders with transcription, processing, and following physician's orders; supervision of LPNAs, RNAs, and nursing students; following care plans; and scheduling appointments. The Nurse Managers, Staff Developed Coordinator (SDC), and DON #3 provided the above education to all licensed nursing stakeholders 04/01/16 through 04/04/16. Any licensed stakeholder that had not received the education by 04/04/16 would be issued a certified letter with the training material. Education and Post Education Competency would be completed by the DON and/or Nurse Managers in person and/or via phone for licensed nurses from 04/01/16 through 04/04/16. When conducting the Post Education Competency via phone, the SDC and/or Nurse Managers would ask the examination questions and document the licensed nurse's response on the examination. The SDC and/or Nurse Managers would follow up with the nurse in person to go over the training material verbally and the stakeholder would complete a written examination with the stakeholder's signature. The SDC and/or Nurse Managers would provide the training to a new stakeholder through the orientation program. The SDC and/or Nurse Manager would provide the Administrator and DON with a verbal progress report of the new stakeholder's performance and/or education skills needed during the orientation process. 5. The Human Resources (HR) Personnel, Receptionist, or Nurse Managers would conduct a KBN online validation report during the interview process for stakeholders applying for a licensed position and when a licensed position status change had occurred. The validation would be printed, reviewed, and signed by the DON, HR Personnel, Receptionist, or Nurse Manager as proof of validation status. The Administrator would conduct the final review. The HR Personnel, Receptionist, or Nurse Managers would conduct monthly and/or needed licensure review via KBN online

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 15) validation report to ensure licenses were valid for three (3) months. If compliance is maintained, audits would be reduced to quarterly for two (2) quarters then annually thereafter. The Corporate Care Consultants would review completed KBN online validation reports daily (Monday-Friday) for four (4) weeks. If compliance is maintained, audits would decrease to two (2) times per week for four (4) weeks to ensure the validation process was completed. The audits would decrease to monthly for three (3) months during their facility visits. 6. The Corporate Care Consultants, Regional Vice President, and/or HR Advisory Personnel would provide ongoing education as needed for new administrative staff. The consultants would provide facility visits a minimum of five (5) days per week for two (2) weeks to review action plan and assist with education needs. If compliance was maintained, the visits would decrease to three (3) per week for eight (8) weeks, then a minimum of monthly thereafter. 7. An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 03/28/16 to review the survey findings and the facility's licensure validation process. Those in attendance included the Administrator, DON, HR Director, Unit Nurse Managers, and the Medical Director. On 03/30/16, a second Ad Hoc QAPI meeting was conducted with the Administrator, DON, Medical Director, Social Services, SDC, and Unit Managers to review policies and procedures related to the hiring and orientation process, and the supervision of LPNAs, RNAs, and student nurses. No changes were made to the hiring process or the Orientation Checklist. The Orientation Checklist for licensed stakeholders would be utilized for LPNAs and RNAs with direct supervision. A new Supervision Policy was created for LPNAs, RNAs, and student nurses on 03/30/16 during the QAPI meeting with the approval of the Medical Director. In addition, the Physical Order/Supplies and Scheduling of Medical Appointments Process was reviewed with no changes. A third Ad Hoc meeting was held on 04/01/16 with the Administrator, DON, and Medical Director via phone to review all recent survey citations and action plans. On 04/04/16, the Administrator and DON met with the Medical Director for overview of the survey findings: F281-discussed the incident with a non-licensed nurse related to Professional Standards with implementation of Licensure Validation Process; F282-discussion of oversight to ensure the care plan was followed; F309-discussed the failure to follow physician orders, provision of supplies, and scheduling of medical appointments; F490-reviewed the role of the Administrator to provide oversight for facility operations. Guidance and oversight would be provided by the Regional Vice President. The Administrator would review all audits and conduct observation rounds. F499- recapped the process for preventing non-licensed staff from working as licensed staff by completing the Licensure Validation Process. F514-reviewed education provided to maintain compliance in the deficient areas, including a post examination. Also reviewed the audit system/tools implemented to monitor processes. Audits would be discussed in the morning meeting, weekly QAPI and monthly QAPI. The IDT team will meet weekly times four (4) weeks to review all audit findings. If compliance was maintained, will reduce to monthly. 8. Order/Supply Process: Licensed nurse (s) would place physician orders on the Medication Record as received. Medical appointments would be scheduled as ordered, including transportation and logged on the monthly calendar. Unit Managers (Nurse Mangers) would review admission/readmission and/or new telephone orders and discuss in the morning clinical meetings (Monday-Friday). Ordered supplies would be discussed in the morning clinical meeting to ensure supplies were available for the resident (s). If the supplies cannot be obtained, a licensed nurse would contact the resident's physician for alternative orders until the supplies were available. 9. The Regional Vice President reviewed administrative duties that included: hiring process, licensure validation, facility oversight, role of the Administrator-in-training, and the job description with the Administrator on 04/04/16. The Regional Vice President will conduct weekly telephone calls with the Administrator for four (4) weeks to discuss current action plans and audit findings. If the facility's operations and oversight meet the residents' needs, the conference call would decrease to monthly for three (3) months, and then quarterly thereafter. If non-compliance is noted, the Vice President would modify oversight as needed to meet the needs of the residents. The State Agency validated removal of the Immediate Jeopardy on 04/07/16 as follows: 1. Review of the Stakeholder Suspension Form revealed the unlicensed stakeholder was suspended on 03/28/16 by the Administrator. Review of a written statement from DON #3 revealed she removed the employee from any licensed nurse duties on 03/14/16. Interview with the DON, on 04/06/16 at 3:29 PM and Administrator, on 04/06/16 at 5:03 PM, validated the stakeholder was suspended on 03/28/16. 2. Review of the facility's licensed staff roster revealed thirty-eight (38) nurses were employed as of 04/06/16. All thirty-eight (38) nurses had a KBN validation report validating they had a valid nursing license. Interview with Corporate Care Consultants #2, and #3, on 04/07/16 at 1:03 AM, revealed the facility had obtained validation of license for all nurses employed by the facility. Received validation reports from the KBN and no stakeholder was working without a license. 3. Review of the medical record review audit sheet revealed forty-three (43) records were reviewed with no problem identified. The audits were conducted on 03/31/16 and 04/01/16 by three (3) Corporate Care Consultants. Interview with Corporate Care Consultants #2 and #3, on 04/07/16 at 10:03 AM, revealed the review of the clinical record found no resident experienced a negative outcome related to the non-licensed stakeholder. The audit did find the nurses were not always signing with credentials. Review of the Medical Record Audit sheets, dated 04/01/16 through 04/06/16, revealed eight (8) to ten (10) residents' records were audited daily by the DON, Nurse Managers, and Corporate Care Consultants. Interview with Consultants #2 and #3, on 04/07/16 at 10:03 AM, West Wing Unit Manager, on 04/06/16 at 3:10 PM, and DON #3, on 04/06/16 at 3:29 PM, revealed medical record audits were being conducted for 5% of the resident census to ensure physician orders were transcribed and processed correctly, licence nurses signed with credentials, and appointments were scheduled as ordered. 4. Review of the training records revealed DON #3, East Unit Manager and West Unit Manager revealed they received training on 04/01/16 on how to audit the medical record and education on legible signatures with credentials, physician orders, supervision of LPNAs, RNAs, and nursing students, following care plans, and scheduling appointments. A post test was taken with the DON and managers scoring 100%. Interview with DON #3, on 04/06/16 at 3:29 PM, revealed she had received the education on the topic above. She then provided training to all licensed nursing stakeholders. She was trained on how to conduct the medical record audits and was involved in conducting those audits. Interview with the East Wing Unit Manager, on 04/06/16 at 11:25 AM, revealed she had been trained to do the medical record audits; however, she had not conducted the audits to date. She revealed she had only been in this position for three (3) weeks and was still learning. Further interview revealed she validated she had received training on physician orders, care plans, scheduling of appointments, documentation to be legible and to include credentials; and, supervision of LPNAs and RNAs. She had not conducted training of the nurses. Interview with the West Wing Unit Manager, on 04/06/16 at 3:10 PM, revealed she had been trained on how to conduct audits of the medical record and had conducted a few over the weekend. She validated she received training on physician orders, documentation in the medical record to be legible with credentials, care plans, scheduling of appointments, physician orders, and supervision of LPNAs and RNAs. She had not conducted training of the nurses. Review of the training records and post test revealed thirty-three (33) licensed nurses and four (4) Certified Medication Technicians were trained on documentation in the medical record that was complete, legible and included credentials. In addition, physician orders, care plans, scheduled appointments, and supervision of LPNAs and RNAs was also reviewed by the survey team. All had passed the post test with a score of 100. Record review revealed five (5) stakeholders had not received the training as of 04/04/16. Certified letters were sent on 04/04/16 to those employees. Copies of the letters were reviewed and the certified mail receipts. A letter written by the Administrator, dated 04/04/16, accompanied the training material. In the letter, the Administrator instructed the licensed nurses they must review the enclosed education material and complete a post test before returning to work. The stakeholder was instructed to turn in the post test and sign the training roster before returning to the facility for a scheduled shift. Validation interviews were conducted on 04/06/16 with LPN #12 at 10:46 AM, LPN #9 at 11:08 AM, LPN #6 at 1:46 PM, LPN #11 at 4:23 PM, and LPN #3 at 4:38 PM, revealed they had received the training and taken the post test. Each nurse had good knowledge of the training topics. Interview with LPN #8, on 04/06/16 at 11:42 AM revealed she needed to complete the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD. RADCLIFF, KY 40160**	

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 16) training. She stated she had been informed of a certified letter, but she had not been to the post office to pick up the certified letter. Therefore, she did not know what the letter contained. She stated she started her work shift today at 6:30 AM and nobody had informed her that she had to complete the training before caring for residents. She stated the Unit Manager had not said anything to her and she had not received any training over the phone. Interview with the West Unit Manager, on 04/16/16 at 11:58 AM, revealed she was unaware the nurse had not received the training. She stated she did realize the DON had not provided training over the phone until the nurse could receive the training in person and taken the post test. Interview with DON #3, on 04/06/16 at 12:06 AM and 12:12 PM, revealed she had called LPN #8 twice and never could reach her. She assumed the nurse had received the certified letter with the training material. She stated she had reviewed the working schedule and didn't realize the nurse was working (that day). She stated it was an oversight and she or the Unit Manager realized she had not been trained. Verification of the nurse's training with a post test was provided to the surveyor on 04/16/16 at 12:10 PM. 5. Review of a newly hired nurse, on 03/29/16, validation check revealed the facility conducted a KBN online validation report on 03/29/16 that revealed the nurse had a valid license. The validation report was reviewed by the HR Personnel, DON #3, Administrator, and Corporate Consultant as indicated by their signatures on the validation report. Review of the training revealed the newly hired nurse had received education on the topics that were included in the AOC. Interview with the HR Director, on 04/06/16 at 4:05 PM, revealed she had received training on the validation process. She stated once an application was received and before an offer letter was sent, she would conduct a validation check with the KBN. After the offer letter was sent another check was conducted at the KBN for abuse registry and a Criminal Background Check would be conducted. She stated she would review the validation report from the KBN then the DON, and the Administrator would do the final check. She stated she assisted with the validation of license for the facility's nurses. The Corporate Consultant signed off as reviewing the hire packet for the newly hired nurse on 04/01/16. The consultant reviewed and signed off on the nurses who are in the interviewing process. 6. Interview with Corporate Care Consultants #2 and #3 and the Special Project Consultant, on 04/07/16 at 10:03 AM revealed they would be providing oversight and assistance to the facility for some time. They stated they have been at the facility daily including some weekend days to conduct audits and assist with educational needs. Consultants #1, #2, and #3 would be at the facility Monday-Friday for several weeks to review action plans, audits, and training before they decrease to three (3) times a week. Once they identify any non-compliance, re-education would be conducted. They were looking at the clinical matrix, and the development of education topics that may include other disciplines beside nursing. The facility did not have a new Administrator in training at the time of the survey. A consultant will attend the clinical meetings to ensure a meeting is held as stated and topics discussed. The consultants reviewed the audits to ensure they were being conducted correctly and to see if there were any training issues. They were in the process of developing an afternoon meeting to recap the day. 7. Review of the QAPI signature sheet, dated 03/28/16, revealed the survey findings were discussed. The Medical Director, Administrator, DON, Corporate Consultant #1, and five (5) other committee members. On 03/30/16, an Ad Hoc meeting was held to discuss the Immediate Jeopardy findings. The Administrator, DON, Unit Managers and SDC was present with the Medical Director
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy and fall event report, it was determined the facility failed to provide adequate supervision to prevent an injurious fall for one of twelve (12) sampled residents (Resident #4). The facility admitted the resident after hospitalization related to a fall at home. The facility assessed the resident to be at risk for additional falls and identified that the resident required physical assistance and supervision during all transfers. On 01/20/16, the resident slipped on the wet shower floor during an unassisted transfer sustaining a fracture to the left humerus, 7th left rib, and 9th thoracic vertebrae. Interview with Certified Nursing Assistant (CNA) #8 revealed he thought the resident required supervision only and turned his back on the resident to obtain the resident's clothing across the shower room. The findings include: Review of the facility's Fall Policy, last reviewed 06/01/15, revealed all residents would have a fall risk assessment completed upon admission and appropriate care plan interventions would be implemented and evaluated, as indicated. After a fall, the Interdisciplinary Team (IDT) would determine the root cause of the fall. Falls resulting from environmental factors would be reviewed at the monthly Safety Committee meeting. Review of Resident #4's closed clinical record revealed the facility admitted the resident on 01/15/16 at 11:30 PM. The resident had [DIAGNOSES REDACTED]. Review of the Nursing Admission Assessment, dated 01/15/16, revealed the facility assessed the resident to require assistance of two (2) staff for bed mobility, transfers, and ambulation. The Fall Risk Evaluation (included in the Admission Assessment) identified the resident at high risk for falling due to a score of eleven (11), with a problem with balance. The nurse assessed the resident's balance to be unsteady, and only stabilized with physical assistance. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility completed a Brief Interview for Mental Status (BIMS) and assessed the resident with a score of fifteen (15) and determined the resident was cognitively intact. Review of the Fall Assessment, dated 01/15/16, revealed the resident had a fall on 01/11/16. Review of the Interim Care Plan, dated 01/15/16, revealed falls were identified as a problem with interventions to verbally remind the resident not to ambulate alone and observe for any unsafe actions and intervene, as needed. Review of the Occupational Therapy evaluation, conducted on 01/18/16, revealed the therapist assessed the resident to have decrease in strength, functional mobility, transfers, activity intolerance, and reduced static and dynamic balance with increased need for assistance from others. The resident was identified at risk for falls, decline in function, and mobility. The therapist assessed the resident's sitting balance to be fair and could maintain with minimum assist. The therapist assessed the resident to need contact guard assistance with all transfers. Review of the Physical Therapist Evaluation, conducted on 01/18/16, revealed the reason for the referral was due to the resident's recent fall and increased weakness. The resident presented with decreased coordination, weakness, and difficulty walking. The resident's standing balance was poor and required moderate assist with upper body support to stand. The therapist assessed the resident to need contact guard assistance of one with sit to stand transfers and gait. The therapist assessed the resident to be at risk for falls with decreased endurance, dizziness, and decreased coordination contributing factors. Review of the Daily Skilled Nurse's Notes, dated 01/19/16 and 01/20/16 revealed two (2) different nurses assessed the resident to require the extensive assistance of two (2) persons for transfers, toilet use, and locomotion. Both nurses assessed the resident to have an unsteady gait and balance problem. Review of a Nurse's Note, dated 01/20/16 at 8:45 PM, revealed the resident was in the shower room with CNA #8, when he/she attempted an unassisted transfer, and fell on to the wet shower floor. The Note stated the resident tried to catch himself/herself. This fall resulted in skin tears to the resident's bilateral forearms. The resident complained of severe pain in his/her left shoulder. The Nurse Practitioner was called and an order was received to send the resident to the emergency room for evaluation of the fall. The resident was transferred to a Trauma Center. Resident #4 was then admitted to the Intensive Care Unit for management of multiple medical problems and the fractures. The resident was in the hospital from 01/21/16 through 01/26/16. Review of the Fall Occurrence Report, dated 01/20/16 at 8:45 PM, revealed interventions in place before the fall included to assist the resident with transfers and ambulation and the environmental factors identified as a cause was the wet shower floor. Review of the functional evaluation section, revealed the facility had assessed the resident to have decreased mobility, needed more assistance with Activity of Daily Living (ADLs) and had falls at home. The root cause of the fall was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 17) determined to be related to the resident ambulating with walker and assist of nurse aide in the shower, slipped and fell causing the fractures. However, interview with CNA #8 revealed that was not how the fall occurred. CNA #8 stated the care plan interventions were to place a towel on the shower floor and the resident was to wear non-slip socks in the shower room. However, review of the Falls Occurance Report stated to place a towel on the floor in the shower to make sure it was not wet when getting up and wear non-skid socks at all times when ambulating. Review of a Falls Alert Progress Note, dated 01/21/16, revealed a summary of the fall by the West Wing Unit Manager. The Manager documented that the resident was ambulating in the shower room with a walker and assist of one nurse aide. The resident's weight shifted and the resident fell on to the shower floor causing the injury. She documented the resident was limited assist of one person for transfers and ambulation. Post fall interventions were as listed above. However, review of CNA #8's written statement revealed the resident fell when he/she was transferring the resident from the shower chair to a wheelchair unassisted. Interview with CNA #8, on 03/17/16 at 2:40 PM, revealed this was the first time he had given Resident #4 a shower. He stated he thought the resident only required supervision with no physical assistance with transfers. CNA #8 stated he brought the resident into the shower room via wheelchair and the resident transferred onto the shower chair. Continued interview revealed he had finished bathing the resident and turned around to get his/her clothing to dress the resident. CNA #8 stated he stepped away from the resident a short distance to the sink counter where the resident's clothing was located. He stated he saw the resident take a step out of the shower chair and slipped on the wet shower floor, face first. He yelled for the nurse and she came to assess the resident. Further interview revealed the Emergency Medical Service (EMS) was called and transported the resident to the hospital. CNA #8 stated he thought the resident was supervision only and didn't require physical assistance with transfers. He stated he thought that was what was on the nurse aide care plan that he was following the day of the resident's fall. However, interview with Unit Manager #1, 03/17/16 at 3:10 PM, revealed the facility's process was not to keep the nurse aide care plans. Once a resident was discharged from the facility, the nurse aide care plan was deleted. The facility did not provide any documented evidence the nurse aide care plan instructed the nurse aides to transfer the resident with supervision only. Continued interview with CNA #8 at 2:40 PM, revealed there was no walker in the shower room when the resident fell as indicated in the Occurrence Report. Another interview with CNA #8, on 04/06/16 at 5:40 PM, revealed he had turned away from the resident to get a towel and the resident's clothing from the sink. He stated he was not within arms length of the resident. The Maintenance Director measured the distance to be five (5) feet and nine (9) inches from the shower chair to the sink. Interview with Licence Practice Nurse (LPN) #11, on 04/06/16 at 4:30 PM, revealed she was standing at the Nurse's Station across from the West Wing Shower Room when CNA #8 yelled out for help. When she entered the shower room she saw Resident #4 laying on the shower floor in front of the shower chair, face down with both arms under him/her. She stated the aide told her he/she had turned around from the resident and the resident attempted an unassisted transfer from the shower chair. She stated the resident complained of left shoulder pain. Further interview revealed she called EMS and the resident was transported to the ER. LPN #11 stated the aides were to follow the nurse aide care plans, which were updated with any changes. She stated the nurse who had completed the admission paperwork, would have initiated the interim care plan using the information from the hospital and the nursing assessment. LPN #11 stated she could not recall what was included on the interim care plan or the nurse aide care plan. During further interview, she stated she recalled the resident was to be transferred with a physical assist of one or two (2) persons, but after the fall, the resident was a total assist. Interview with the West Wing Unit Manager #1, on 03/17/16 at 3:10 PM, revealed she conducted the fall investigation for Resident #4. She was not at the facility when the fall occurred, but investigated the fall the next day. The Unit Manager stated she did not recall what mode of transfer was on the nurse aide care plan before the resident's fall. She stated she could not provide a copy of the care plan since the resident had been discharged from the facility, and the facility does not keep the nurse aide care plans. She stated couldn't recall what was on the care plan. Continued interview with Unit Manager #1 revealed she determine the root cause of the fall to be the resident slipped in water on the shower floor when transferring from the shower chair. She stated during the investigation, it was reported to her the resident had a walker. During further interview she stated the resident's transfer mode was physical assistance of one person. She stated immediate interventions after the fall was to place towels on the shower floor and place non-slip socks on the resident in the shower room. Another interview with the West Wing Unit Manager #1, on 03/17/16 at 5:37 PM, revealed any fall a resident sustained [REDACTED]. However, she could not recall if Resident #4's fall was discussed. She stated she had interviewed the resident upon return to the facility (01/26/16) and the resident told her that he/she was trying to help and took a few steps and fell . The Unit Manager had no documented evidence of the interview with the resident; however, the Unit Manager had completed the fall Summary Note on 01/21/16, prior to the interview with the resident. She stated therapy attended the Morning Clinical meetings and discussed the resident's functional ability. The Unit Manager stated nursing had determined the resident needed the physical assistance of one person for transfers. She stated the facility used the nurse aide care plan to communicate the resident's assistance needs. A telephone interview with CNA #7, on 03/17/16 at 6:45 PM, revealed she had cared for Resident #4 on 01/19/16. She stated the resident required assistance of one person for transfers. According to CNA #7, the resident used an electric wheelchair and was independent once in the chair. She stated the nurse aide care plan instructed to transfer the resident with two (2) persons. Continued review of the clinical record revealed the Comprehensive Care Plan was not developed until 02/04/16 after the resident's injurious fall. Interview with the Occupational Therapist, on 03/29/16 at 10:55 AM, who conducted the above evaluation for Resident #4, revealed the resident was minimum assist of one (physical) for transfers from the toilet (sit to stand). The resident used a walker with encouragement, but had a powered chair. She stated the resident was at risk for falling. Further interview revealed the resident's sitting balance was fair when holding onto the gym bed for support and his/her standing balance was fair when the resident held onto a person or object. Interview with the Physical Therapist, on 03/29/16 at 10:55 AM, revealed the resident required contact guard assist from the bed to a chair. She stated physical touch, holding a hand, was required, but you did not have to physically pull the resident up from a chair. However, you needed to be right there beside the resident. She had conducted the evaluation of the resident on 01/18/16 and found the resident to be at risk for falls. She conducted a Tinetti test (assessment for balance and gait) with the resident scoring a twelve (12) out of possible twenty-eight (28) indicating high risk for falls. Below a 19 or 20 indicated high risk for falls. She stated during the working session the resident required minimum assistance of one person and would not be supervised only. She stated she had only begun working with the resident when he/she had the fall, but the resident would never have been supervision only. According to the Physical Therapist, communication between therapy and nursing regarding a resident's functional mobility would take place in the Clinical Meetings. Interview with the Administrator, on 03/17/16 at 5:45 PM, revealed falls resulting from environmental factors would be reviewed at the monthly Safety Committee Meeting. She stated the last meeting was held on 02/29/16. The Administrator stated the committee had not discussed this specific fall. During further interview, she stated she would not have considered wet floors in the shower rooms as an environmental cause as you would expect a wet floor. She stated the resident's fall would have been discussed at the Fall Committee Meeting. The Administrator stated that the committee tracks and trends the falls. She said white board meetings were held each morning and the resident's fall should have been discussed the following morning (01/21/16). She recalled talking about the aide turning to get something and the resident fell . An immediate intervention was to place towels on the floor. The facility tried to place black non-slip strips, but it did not work. A sticky substance had been put on the shower room floors. She stated the committee had not looked at the fact CNA #8 turned his back to the resident.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, it was determined the facility failed to ensure the Administrator was onsite providing oversight to the Administrator In Training (AIT) and providing assistance with administrative decision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 18) making. On 11/30/15, the AIT signed for approval to hire an unlicensed Graduate Nurse who did not possess a valid provisional license to function as a Practical Nurse Applicant. The facility's failure to ensure Administrative oversight to an AIT and provision of assistance with administrative decision making placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/31/16 and determined to exist on 11/30/15. The facility was notified on the Immediate Jeopardy on 03/31/16. The facility provided an acceptable Allegation of Compliance (AOC) on 04/04/16, which alleged removal of Immediate Jeopardy on 04/05/16. The State Survey Agency (SSA) verified the Immediate Jeopardy was not removed on 04/05/16 as alleged, but on 04/07/16 (facility allowed a nurse to return to work without training on 04/06/16) prior to exit on 04/08/16. The scope and severity was lowered to an E while the facility develops and implements a plan of correction and the Quality Assurance monitors for effectiveness of the systemic changes. The findings include: Interview with the Human Resource (HR) Assistant, on 03/30/16 at 2:05 PM, revealed it was her job to print off the nurse aid abuse check, nursing license and background checks (Investigative Information Report Form) and place it in the Administrators mailbox for review. Review of the Unlicensed Graduate Nurse's Investigative Information Report Form, request date of 11/18/15, revealed the Administrator signed her signature and dated the form 11/30/15. Interview with the Administrator in Training (AIT)/Admission Coordinator, on 03/30/15 at 1:35 PM, revealed she was the Administrator in Training from late October 2015 until February 2016 and was under a couple of Interim Administrators; Interim Administrator #1, #2 and #3. The AIT/Admission Coordinator stated some of her tasks included to sign off on background checks. She would check for felonies, misdemeanors and if they occurred she would look back at how many years. The AIT/Admission Coordinator stated she remembered the Staff Development Coordinator shoving in her face documents to sign and she thought she was signing the form for the background check, not to give approval for the employment of the Unlicensed Graduate Nurse. She stated she was told to sign the form because the background check had to be reviewed. She further stated she had not been educated on the hiring process. The AIT/Admission Coordinator stated when there was an Administrator in Training there was to be an Administrator on the premises. She stated some days Interim Administrator #1 was not present and instructed her to call if she had questions. She stated sometimes she would not get a response back if she had a question about a document. The AIT/Admission Coordinator stated she told Corporate at the time of her concern and she thought the Corporation felt there was no concern. The AIT/Admission Coordinator reviewed the Unlicensed Graduate Nurse's new hire documents and stated it looked like she gave the approval for hire and she was not aware she was doing that. The AIT/Admission Coordinator stated she thought if nurses did not have a license they could not work and there was no policy about graduate nurses working for ninety (90) days without a provisional license. Interview with the Staff Development Coordinator (SDC), on 03/30/16 at 2:00 PM, revealed she did not recall having the AIT sign the approval for the Unlicensed Graduate Nurse to work. Interview via telephone with Interim Administrator #1, on 03/31/16 at 9:07 AM, revealed he worked in the facility as the Interim Administrator from October 2015 until 11/30/15. He stated 11/30/15 was his last day. Interim Administrator #1 stated there was an Administrator In Training and he was aware she did not have a license, although she was functioning as the Assistant Administrator. He stated there were times when the Administrator in Training was left working by herself, stating that it was not required to have a Licensed Administrator in the building at all times. According to Interim Administrator #1 the AIT was essentially an Assistant to the Administrator and was not making administrative decisions. Interim Administrator #1 stated he was not familiar with the Unlicensed Graduate Nurse and was not aware nor involved with the hiring of the employee. According to Interim Administrator #1, he was not sure if he trained the AIT regarding the reviewing of Human Resource Documents. The AIT should have called him if she had any questions. The Unlicensed Graduate Nurse should not have been hired without a license. Interview via telephone with Interim Administrator #2, on 03/30/16 at 3:37 PM, revealed he worked from 12/01/15 through January 2016 about twenty-five (25) days as the Interim Administrator. Further interview revealed that he and the Administrator in Training would look at questionable background checks of new employees and would sign for approval to hire. According to Interim Administrator #2, he was always with the Administrator in Training and an Administrator in Training was not to be left alone. Further interview with Interim Administrator #2 revealed he worked seven (7) days a week and did not know of any Unlicensed Graduate Nurse working as a nurse. He stated if the Administrator In Training signed for the approval of a new hire, he would want to see the form to review. The Interim Administrator stated he signed all documents after 12/01/16. Interview with the current Director of Nursing (DON) #3, on 03/30/16 at 3:45 PM, revealed Interim Administrator #1 was the Administrator until 11/30/15. DON #3 stated Interim Administrator #1 would leave the Administrator In Training by her self all the time. She stated if the facility had questions they would call Interim Administrator #1. DON #3 further stated she did not remember the Interim Administrator being in the building. Interview with DON #2, on 03/31/16 at 9:28 AM, revealed the SDC was completing all of the new hires at that time and Corporate was sending the SDC resumes of potential hires. The DON stated so if a nurse did not have a provisional license she should not have been working because the residents could have been harmed. Interview with Administrator #3, on 03/30/16 at 3:55 PM, revealed if there was a question about a staff member's background check, the staff would ask the Administrator for approval to hire. Administrator #3 stated she would review the Investigative Information Report Form and look at the whole document. The Administrator stated she would check the offenses, but probably not the Kentucky Board of Nursing licensure, because she would assume that had already been checked by Human Resources. Administrator #3 stated an AIT would not make Administrative decisions because they do not have a license and that was out of their scope of practice. She stated the AIT staff could not be left alone in a facility to make Administrative decisions. The facility took the following actions to remove the Immediate Jeopardy: 1. On 03/14/16, DON #3 removed the stakeholder (Unlicensed Graduate Nurse), who did not have a provisional, from the LPNA role. On 03/28/16, the Administrator suspended the stakeholder. 2. The Corporate Care Consultants reviewed and validated thirty-one (31) stakeholders working as licensed nurses on 03/28/16; and, seven (7) were validated on 04/01/16 via the Kentucky Board of Nursing (KBN) online verification report. No stakeholder was found to be working without a valid nursing license. 3. The Corporate Care Consultants reviewed all current residents medical records that were assigned to the non-licensed stakeholder. Forty-one (41) charts were reviewed on 03/31/16; and, nine (9) were reviewed on 04/01/16. Of the fifty (50) charts reviewed, no care issues were noted related to the non-licensed stakeholder. The facility identified twenty-one (21) clinical records that had missing credentials. The DON and Nurse Managers began education addressing appropriate signage of the medical record including credentials for the unlicensed nursee. The facility implemented a Medical Record Review Process on 04/04/16 by the DON. The DON and/or Nurse Managers would review the medical record (physician's orders [REDACTED]. Five (5) percent of the current census would be reviewed for physician orders, nurses's notes and assessments in the daily clinical meeting (Monday-Friday) for two (2) weeks; if compliance was maintained, audits would decrease to 5% three (3) times a week for four (4) weeks, and then monthly for three (3) months. 4. The Consultants provided education to the DON and Nurse Managers on 04/01/16, on the process of auditing of the medical record(s). The education consisted of: legible signature to include credentials; physician orders [REDACTED]. The Nurse Managers, Staff Developed Coordinator (SDC), and DON #3 provided the above education to all licensed nursing stakeholders 04/01/16 through 04/04/16. Any licensed stakeholder that had not received the education by 04/04/16 would be issued a certified letter with the training material. Education and Post Education Competency would be completed by the DON and/or Nurse Managers in person and/or via phone for licensed nurses from 04/01/16 through 04/04/16. When conducting the Post Education Competency via phone, the SDC and/or Nurse Managers would ask the examination questions and document the licensed nurse's response on the examination. The SDC and/or Nurse Managers would follow up with the nurse in person to go over the training material verbally and the stakeholder would complete a written examination with the stakeholder's signature. The SDC and/or Nurse Managers would provide the training to a new stakeholder through the orientation program. The SDC and/or Nurse Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD. RADCLIFF, KY 40160**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 19) would provide the Administrator and DON with a verbal progress report of the new stakeholder's performance and/or education skills needed during the orientation process. 5. The Human Resources (HR) Personnel, Receptionist, or Nurse Managers would conduct a KBN online validation report during the interview process for stakeholders applying for a licensed position and when a licensed position status change had occurred. The validation would be printed, reviewed, and signed by the DON, HR Personnel, Receptionist, or Nurse Manager as proof of validation status. The Administrator would conduct the final review. The HR Personnel, Receptionist, or Nurse Managers would conduct monthly and/or needed licensure review via KBN online validation report to ensure licenses were valid for three (3) months. If compliance is maintained, audits would be reduced to quarterly for two (2) quarters then annually thereafter. The Corporate Care Consultants would review completed KBN online validation reports daily (Monday-Friday) for four (4) weeks. If compliance is maintained, audits would decrease to two (2) times per week for four (4) weeks to ensure the validation process was completed. The audits would decrease to monthly for three (3) months during their facility visits. 6. The Corporate Care Consultants, Regional Vice President, and/or HR Advisory Personnel would provide ongoing education as needed for new administrative staff. The consultants would provide facility visits a minimum of five (5) days per week for two (2) weeks to review action plan and assist with education needs. If compliance was maintained, the visits would decrease to three (3) per week for eight (8) weeks, then a minimum of monthly thereafter. 7. An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 03/28/16 to review the survey findings and the facility's licensure validation process. Those in attendance included the Administrator, DON, HR Director, Unit Nurse Managers, and the Medical Director. On 03/30/16, a second Ad Hoc QAPI meeting was conducted with the Administrator, DON, Medical Director, Social Services, SDC, and Unit Managers to review policies and procedures related to the hiring and orientation process, and the supervision of LPNAs, RNAs, and student nurses. No changes were made to the hiring process or the Orientation Checklist. The Orientation Checklist for licensed stakeholders would be utilized for LPNAs and RNAs with direct supervision. A new Supervision Policy was created for LPNAs, RNAs, and student nurses on 03/30/16 during the QAPI meeting with the approval of the Medical Director. In addition, the Physical Order/Supplies and Scheduling of Medical Appointments Process was reviewed with no changes. A third Ad Hoc meeting was held on 04/01/16 with the Administrator, DON, and Medical Director via phone to review all recent survey citations and action plans. On 04/04/16, the Administrator and DON met with the Medical Director for overview of the survey findings: F281-discussed the incident with a non-licensed nurse related to Professional Standards with implementation of Licensure Validation Process; F282-discussion of oversight to ensure the care plan was followed; F309-discussed the failure to follow physician orders, provision of supplies, and scheduling of medical appointments; F490-reviewed the role of the Administrator to provide oversight for facility operations. Guidance and oversight would be provided by the Regional Vice President. The Administrator would review all audits and conduct observation rounds. F499- recapped the process for preventing non-licensed staff from working as licensed staff by completing the Licensure Validation Process. F514-reviewed education provided to maintain compliance in the deficient areas, including a post examination. Also reviewed the audit system/tools implemented to monitor processes. Audits would be discussed in the morning meeting, weekly QAPI and monthly QAPI. The IDT team will meet weekly times four (4) weeks to review all audit findings. If compliance was maintained, will reduce to monthly. 8. Order/Supply Process: Licensed nurse (s) would place physician orders [REDACTED]. Medical appointments would be scheduled as ordered, including transportation and logged on the monthly calendar. Unit Managers (Nurse Mangers) would review admission/readmission and/or new telephone orders and discuss in the morning clinical meetings (Monday-Friday). Ordered supplies would be discussed in the morning clinical meeting to ensure supplies were available for the resident (s). If the supplies cannot be obtained, a licensed nurse would contact the resident's physician for alternative orders until the supplies were available. 9. The Regional Vice President reviewed administrative duties that included: hiring process, licensure validation, facility oversight, role of the Administrator-in-training, and the job description with the Administrator on 04/04/16. The Regional Vice President will conduct weekly telephone calls with the Administrator for four (4) weeks to discuss current action plans and audit findings. If the facility's operations and oversight meet the residents' needs, the conference call would decrease to monthly for three (3) months, and then quarterly thereafter. If non-compliance is noted, the Vice President would modify oversight as needed to meet the needs of the residents. The State Agency validated removal of the Immediate Jeopardy on 04/07/16 as follows: 1. Review of the Stakeholder Suspension Form revealed the unlicensed stakeholder was suspended on 03/28/16 by the Administrator. Review of a written statement from DON #3 revealed she removed the employee from any licensed nurse duties on 03/14/16. Interview with the DON, on 04/06/16 at 3:29 PM and Administrator, on 04/06/16 at 5:03 PM, validated the stakeholder was suspended on 03/28/16. 2. Review of the facility's licensed staff roster revealed thirty-eight (38) nurses were employed as of 04/06/16. All thirty-eight (38) nurses had a KBN validation report validating they had a valid nursing license. Interview with Corporate Care Consultants #2, and #3, on 04/07/16 at 1:03 AM, revealed the facility had obtained validation of license for all nurses employed by the facility. Received validation reports from the KBN and no stakeholder was working without a license. 3. Review of the medical record review audit sheet revealed forty-three (43) records were reviewed with no problem identified. The audits were conducted on 03/31/16 and 04/01/16 by three (3) Corporate Care Consultants. Interview with Corporate Care Consultants #2 and #3, on 04/07/16 at 10:03 AM, revealed the review of the clinical record found no resident experienced a negative outcome related to the non-licensed stakeholder. The audit did find the nurses were not always signing with credentials. Review of the Medical Record Audit sheets, dated 04/01/16 through 04/06/16, revealed eight (8) to ten (10) residents' records were audited daily by the DON, Nurse Managers, and Corporate Care Consultants. Interview with Consultants #2 and #3, on 04/07/16 at 10:03 AM, West Wing Unit Manager, on 04/06/16 at 3:10 PM, and DON #3, on 04/06/16 at 3:29 PM, revealed medical record audits were being conducted for 5% of the resident census to ensure physician orders [REDACTED]. 4. Review of the training records revealed DON #3, East Unit Manager and West Unit Manager revealed they received training on 04/01/16 on how to audit the medical record and education on legible signatures with credentials, physician orders, supervision of LPNAs, RNAs, and nursing students, following care plans, and scheduling appointments. A post test was taken with the DON and managers scoring 100%. Interview with DON #3, on 04/06/16 at 3:29 PM, revealed she had received the education on the topic above. She then provided training to all licensed nursing stakeholders. She was trained on how to conduct the medical record audits and was involved in conducting those audits. Interview with the East Wing Unit Manager, on 04/06/16 at 11:25 AM, revealed she had been trained to do the medical record audits; however, she had not conducted the audits to date. She revealed she had only been in this position for three (3) weeks and was still learning. Further interview revealed she validated she had received training on physician orders, care plans, scheduling of appointments, documentation to be legible and to include credentials; and, supervision of LPNAs and RNAs. She had not conducted training of the nurses. Interview with the West Wing Unit Manager, on 04/06/16 at 3:10 PM, revealed she had been trained on how to conduct audits of the medical record and had conducted a few over the weekend. She validated she received training on physician orders, documentation in the medical record to be legible with credentials, care plans, scheduling of appointments, physician orders, and supervision of LPNAs and RNAs. She had not conducted training of the nurses. Review of the training records and post test revealed thirty-three (33) licensed nurses and four (4) Certified Medication Technicians were trained on documentation in the medical record that was complete, legible and included credentials. In addition, physician orders, care plans, scheduled appointments, and supervision of LPNAs and RNAs was also reviewed by the survey team. All had passed the post test with a score of 100. Record review revealed five (5) stakeholders had not received the training as of 04/04/16. Certified letters were sent on 04/04/16 to those employees. Copies of the letters were reviewed and the certified mail receipts. A letter written by the Administrator, dated 04/04/16, accompanied the training material. In the letter, the Administrator instructed the licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185180		**04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 20) nurses they must review the enclosed education material and complete a post test before returning to work. The stakeholder was instructed to turn in the post test and sign the training roster before returning to the facility for a scheduled shift. Validation interviews were conducted on 04/06/16 with LPN #12 at 10:46 AM, LPN #9 at 11:08 AM, LPN #6 at 1:46 PM, LPN #11 at 4:23 PM, and LPN #3 at 4:38 PM, revealed they had received the training and taken the post test. Each nurse had good knowledge of the training topics. Interview with LPN #8, on 04/06/16 at 11:42 AM revealed she needed to complete the training. She stated she had been informed of a certified letter, but she had not been to the post office to pick up the certified letter. Therefore, she did not know what the letter contained. She stated she started her work shift today at 6:30 AM and nobody had informed her that she had to complete the training before caring for residents. She stated the Unit Manager had not said anything to her and she had not received any training over the phone. Interview with the West Unit Manager, on 04/16/16 at 11:58 AM, revealed she was unaware the nurse had not received the training. She stated she did realize the DON had not provided training over the phone until the nurse could receive the training in person and taken the post test. Interview with DON #3, on 04/06/16 at 12:06 AM and 12:12 PM, revealed she had called LPN #8 twice and never could reach her. She assumed the nurse had received the certified letter with the training material. She stated she had reviewed the working schedule and didn't realize the nurse was working (that day). She stated it was an oversight and she or the Unit Manager realized she had not been trained. Verification of the nurse's training with a post test was provided to the surveyor on 04/16/16 at 12:10 PM. 5. Review of a newly hired nurse, on 03/29/16, validation check revealed the facility conducted a KBN online validation report on 03/29/16 that revealed the nurse had a valid license. The validation report was reviewed by the HR Personnel, DON #3, Administrator, and Corporate Consultant as indicated by their signatures on the validation report. Review of the training revealed the newly hired nurse had received education on the topics that were included in the AOC. Interview with the HR Director, on 04/06/16 at 4:05 PM, revealed she had received training on the validation process. She stated once an application was received and before an offer letter was sent, she would conduct a validation check with the KBN. After the offer letter was sent another check was conducted at the KBN for abuse registry and a Criminal Background Check would be conducted. She stated she would review the validation report from the KBN then the DON, and the Administrator would do the final check. She stated she assisted with the validation of license for the facility's nurses. The Corporate Consultant signed off as reviewing the hire packet for the newly hired nurse on 04/01/16. The consultant reviewed and signed off on the nurses who are in the interviewing process. 6. Interview with Corporate Care Consultants #2 and #3 and the Special Project Consultant, on 04/07/16 at 10:03 AM revealed they would be providing oversight and assistance to the facility for some time. They stated they have been at the facility daily including some weekend days to conduct audits and assist with educational needs. Consultants #1, #2, and #3 would be at the facility Monday-Friday for several weeks to review action plans, audits, and training before they decrease to three (3) times a week. Once they identify any non-compliance, re-education would be conducted. They were looking at the clinical matrix, and the development of education topics that may include other disciplines beside nursing. The facility did not have a new Administrator in training at the time of the survey. A consultant will attend the clinical meetings to ensure a meeting is held as stated and topics discussed. The consultants reviewed the audits to ensure they were being conducted correctly and to see if there were any training issues. They were in the process of developing an afternoon meeting to recap the day. 7. Review of the QAPI signature sheet, dated 03/28/16, revealed the survey findings were discussed. The Medical Director, Administrator, DON, Corporate Consultant #1, and five (5) other committee members. On 03/30/16, an Ad Hoc meeting was held to discuss the Immediate Jeopardy findings. The Administrator, DON, Unit Managers and SDC was present with the Medical Director via phone conference. Additional Ad Hoc QAPI meetings were held on 04/01/16, 04/04/16 and 04/06/16. Interview with the Administrator, on 04/06/16 at 5:03 PM, validated the above QAPI meetings were held. She stated she conducted the meetings and the Medical Director was either present in person or via phone. She stated the frequent QAPI meetings were to review what process had been changed and were they effective. The committee reviewed the audits. She stated the audits were also reviewed in the morning meetings before they were reviewed in the QAPI meetings. She stated she will conduct a weekly QAPI meeting for the next month. In addition, the IDT meet weekly to review the audits. Interview with the Medical Director, on 04/06/16 at 4:48 PM, revealed he had been involved in the whole process since the beginning of the Immediate Jeopardy. The facility's Administrator provided him an overview of the survey findings and requested his input in the corrective plans. He reviewed the policies and validation process and discussed the physician orders [REDACTED]. 8. Review of Unsampled Residents L's and M's record revealed physician orders [REDACTED]. Review of the appointment calendar revealed the scheduled appointment had been placed in the calendar with transportation obtained. Review of the appointment calendars for the East and West Units and audits revealed no missed appointments. 9. Review of the education provided by the Regional Vice President to the Administrator and DON #3, on 04/04/16, revealed the training was on F490 and review of the Administrator's job description. A telephone interview with the Regional Vice President, on 04/07/16 at 9:54 AM, revealed he validated the training provided to the facility's Administrator. He stated he reviewed the role of the Administrator and responsibilities related to the hiring process, licensure validation, facility oversight, and Administrator in training. He stated the Administrator would provide oversight through observation rounds and review of clinical meeting findings. He stated he would conduct weekly telephone conference calls with the Administrator to discuss current corrective action plans, audit findings, facility operation, and oversight met the residents' needs. He would conduct the weekly calls for four (4) weeks and then decrease to monthly times three (3) months, then quarterly.
F 0499 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Employ qualified full-time, part-time or consultant professionals that must be licensed, certified, or registered staff to give needed services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy review and review of the Kentucky Board of Nursing Laws, it was determined the facility failed to ensure an Unlicensed Graduate Nurse was licensed in accordance with state laws (Kentucky Regulatory Statutes 314.031 and 314.051) for one (1) of one (1) Unlicensed Graduate Nurse of the Licensed Practical Nurse (LPN) Program. On 11/30/15, the facility hired an Unlicensed Graduate Nurse of a Licensed Practical Nurse Program to function as an Licensed Practical Nurse Applicant (LPNA). However, the facility failed to ensure the Graduate Nurse held a provisional license to perform the duties as a Licensed Practical Nurse Applicant. Duties of a LPNA included direct the day-to-day functions of the nursing assistants; make reports and recommendations of shift, periodically review/update discharge plans, admit, transfer and discharge residents, complete accident and incident reports, complete and file forms/charts, physicians orders, medication cards, treatments and care plans, record new/changed diet orders, routine charting and entries, nurses notes, prepare and administer medication, order prescribed medications, verify narcotic records were accurate, round and consult with physicians. The Unlicensed Graduate Nurse documented the care she provided to residents including clinical assessments, medication administration, treatments, diabetic care that included insulin injections, and [MEDICATION NAME] flushes for an intravenous (IV) line as a Licensed Practical Nurse Applicant (LPNA). The facility failed to have an effective system in place for hiring and ensuring unlicensed professional staff had the appropriate credentials upon hire, placing residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/30/16 and determined to exist on 11/30/15. The facility was notified of the Immediate Jeopardy on 03/30/16. The facility provided an acceptable Allegation of Compliance (AOC) on 04/04/16, which alleged removal of Immediate Jeopardy on 04/05/16. The State Survey Agency (SSA) verified the Immediate Jeopardy was not removed on 04/05/16 as alleged, but on 04/07/16 (facility allowed a nurse to return to work without training on 04/06/16) prior to exit on 04/08/16. The scope and severity was lowered to an E while the facility develops and implements the plan of correction and the Quality Assurance monitors for effectiveness of the systemic changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0499

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 21)
The findings include:
Review of the facility's Licensure and Certification Compliance Functions Policy, revised November 2015, revealed it was the policy of the company that all positions requiring professional licenses or certifications would be filled only by persons holding such license or certifications. It was the obligation of the Stakeholder to verify their information with their respective licensure/certification boards and maintain their license/certification. Any actions taken against a stakeholder's license would be subject to review by the company, and employment action may be taken, up to and including termination. It was the responsibility of the Compliance Department to ensure that all appropriate adjustments were completed based on lapse, inactive, invalid or termination license or certification.
Review of the Kentucky Board of Nursing (KBN), Kentucky Nursing Laws, effective June 01, 2007, Unlawful Acts Related to Nursing, page 8, KRS 314.031 revealed it shall be unlawful for any person to call or hold herself or himself out as or use the title of nurse or to practice or offer to practice as a nurse unless licensed or privileged under the provisions of this chapter. It shall be unlawful for any person knowingly to employee a nurse unless the nurse is licensed or privileged under the provisions of this chapter. It shall be unlawful if not reported to the board a person who is [MEDICATION NAME] nursing without a current active license, privilege, or valid temporary work permit issued by the board. KRS 314.051 revealed an LPNA shall only work under the direct supervision of a nurse and shall not engage in independent nursing practice. No other person shall assume the title or use the abbreviation or any other words, letters, signs, or figures to indicate that the person using the same is a licensed practical nurse. No person shall practice as a licensed practical nurse unless licensed under this chapter. Review of the KBN website, not dated, revealed a provisional license would be issued within fourteen (14) days of meeting all application requirements. The provisional license would be valid for a period of six (6) months from the date issued. It instructed the potential employee to not begin employment as an Licensed Practical Nurse Applicant (LPNA) until they had been issued a provisional license by the KBN.
Review of the Charge Nurse Licensed Practical Nurse (LPN) or Registered Nurse (RN) Job Description with a handwritten notation at the top of LPNA, dated 12/04/15, revealed the Unlicensed Graduate Nurse signed the job description for a Charge Nurse. Review of the Job Description Summary, revealed the Licensed Practical Nurse Applicant would provide direct nursing care to the residents and supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current Federal, State and Local standards, guidelines, and regulations that govern the facility, and may also be required by the Director of Nursing to maintain the highest degree of quality care at all times. Some Essential Duties and Responsibilities were; to direct the day-to-day functions of the nursing assistants in accordance with rules, regulations and confirm that all nursing personnel assigned comply with the written policies and procedures, make written and oral reports/recommendations concerning the activities of your shift, periodically review the residents' written discharge plans, participate in the updating of the residents' written discharge plans, admit transfer and discharge residents, complete accident and incident reports as necessary, complete and file required forms/charts, receive telephone orders from physicians and record on the Physicians' Order form, transcribe physician orders [REDACTED].'s physician. The Job Requirement stated the nurse was to have the ability to work with minimal supervision, take initiative and make independent decisions. This description was for a LPNA; however, the Graduate Nurse was not a LPNA.
Interview with LPN #7, on 03/29/15 at 1:45 PM, revealed she began work at the facility when she had a provisional license. She stated the facility would not let her work until she had one.
Interview with LPN #8, on 03/29/16 at 4:00 PM, revealed she had been a nurse since 2006 and had a license when she was hired by the facility. LPN #8 stated she witnessed an Unlicensed Graduate Nurse work as a nurse on the 600 Unit (Rehabilitation Unit). LPN #8 stated she completed narcotic counts and had given report to the Unlicensed Graduate Nurse; however, LPN #8 was not aware the Unlicensed Graduate Nurse did not have a license.
Interview with LPN #10, on 03/29/16 at 4:10 PM, revealed she had worked with the Unlicensed Graduate Nurse. She stated she observed the Unlicensed Graduate Nurse completing medication pass, treatments, and obtaining and writing orders from physicians. LPN #10 stated she even helped the Graduate Nurse with an Intravenous (IV). LPN #10 stated the Unlicensed Graduate Nurse reported she had a provisional license.
Interview with the Director of the Night Time (PM) Practical Nursing Program for the Unlicensed Graduate Nurse, on 03/30/16 at 4:25 PM, revealed the Unlicensed Graduate Nurse graduated from a Practical Nurse Program on September of 2015. He stated the nursing students were to have a provisional license before they could work and once they received their provisional license they could sit for boards (test to get license). The Director of the PM Practical Nursing Program stated if an unlicensed nurse was working without a provisional license, they would be working out of their scope of practice.
Review of the Unlicensed Graduate Nurse's employee file, revealed she was hired as an LPNA on 11/30/15 and was to start work on the second (2nd) shift.
Interview with the Unlicensed Graduate Nurse, on 03/28/16 at 1:56 PM, revealed she was told she could work for ninety (90) days before she obtained her license. She started working at the facility on 11/30/15. The Unlicensed Graduate Nurse stated the Director of Nursing (DON) #1 was well aware she did not have a provisional license and she had given the DON all the paper work after she had given it to the KBN for her provisional license. However, the Unlicensed Graduate Nurse stated the background check was not acceptable to the KBN and needed further review, thus a provisional license was not issued to her. The Unlicensed Graduate Nurse stated she was told by the school to obtain a provisional license, but no one informed her that she could not work without the provisional license.
Further interview with the Unlicensed Graduate Nurse, on 03/31/16 at 10:30 AM, revealed she also let the Staff Development Coordinator (SDC) know when she was hired that she had applied for a provisional license. The SDC was one-hundred (100) percent (%) aware of everything.
Interview with the Staff Development Coordinator (SDC), on 03/30/16 at 9:52 AM, revealed she remembered completing the Unlicensed Graduate Nurse new hire interview and the Unlicensed Graduate Nurse told the SDC that she was applying for an LPNA position. The SDC stated she asked the Unlicensed Graduate Nurse questions like; what type of education, work experience, prior facilities worked, what was her best work experience and what would you do if a resident was yelling at you? The SDC stated the Unlicensed Graduate Nurse informed her she had completed her nursing education, but did not recall her saying she worked anywhere else. On the Unlicensed Practical Nurse's application it showed that it was completed and signed for approval to hire. The SDC stated she was under the impression that graduate nurses could work without a provisional license for ninety (90) days and she did not check if there was a provisional license.
Further interview with the SDC, 03/29/16 at 11:35 AM, revealed she was told by DON #1 that she could hire the Unlicensed Graduate Nurse for ninety (90) days as a nurse and to start orientation as a Licensed Practical Nurse Applicant (LPNA). The SDC stated the person responsible to validate licensure was the Human Resource (HR) Department. The HR Department completed the background checks and the check list. The SDC stated she asked the Unlicensed Graduate Nurse about a license and the scheduling of boards, but the Unlicensed Graduate Nurse stated she was clearing something off of her record with the KBN before she could sit for boards. The SDC stated she was not aware applicants could not work without a provisional license.
Interview with Director of Nursing (DON) #1, on 03/30/16 at 9:30 AM, revealed her last day in the facility was on 12/11/15. DON #1 stated she knew that as a Licensed Practical Nurse Applicant (LPNA) the graduate nurse could work for ninety (90) days. If there was a policy that did not support the fact that the Unlicensed Graduate Nurse could work for ninety (90) days without a license; DON #1 was not aware. According to DON #1 the only time she got involved with the hiring process was when she would meet with the individual to see if she wanted to hire them. She stated the SDC was responsible to interview new hires and the SDC agreed the Unlicensed Graduate Nurse could work as an LPNA. DON #1 stated it was not her role to check licensure and no one came to her asking her to verify the license of the Unlicensed Graduate Nurse. DON #1 further stated she did not tell anyone that it was the policy of the facility that an unlicensed staff member could work for ninety (90) days without a license. DON #1 never spoke to DON #2 about the Unlicensed Graduate Nurse. DON #1 stated that criminal charges could occur if a staff member was working without a license on a nursing unit.
Interview with DON #2, on 03/31/16 at 9:28 AM, revealed she worked at the facility from 01/14/16 through 03/10/16 and remembered the Unlicensed Graduate Nurse; however, she was not aware the Unlicensed Graduate Nurse did not have a provisional license to work. DON #2 stated she remembered talking to the SDC and Human Resource (did not remember what date) about when the Unlicensed Graduate Nurse was going to take his/her nursing boards. According to DON #2 the SDC told her at that time, the Unlicensed Graduate Nurse was a LPNA and had thirty (30) days left until she was to take the nursing boards. DON #2 stated if she would have known the Unlicensed Graduate Nurse did not have a provisional license, she would not have let her work.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**
NAME OF PROVIDER OF SUPPLIER **SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN**		STREET ADDRESS, CITY, STATE, ZIP **599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**	

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 0499 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 22) Interview with Human Resource (HR), on 03/30/16 at 9:10 AM, revealed when the Unlicensed Graduate Nurse was hired she was in orientation and was not involved in the hiring process. HR stated she remembered late February and early March the SDC mentioned that DON #1 had informed her the Unlicensed Graduate Nurse could work for ninety (90) days before obtaining a license. The HR remembered then taking this information to DON #2. DON #2 stated they were working on it and it had been resolved. March 10th was DON #2's last day at the facility. HR stated she had never been trained that an individual could work for ninety (90) days without a license. Only licensed staff could work as a nurse. Interview with the Staff Development Coordinator (SDC), 03/29/16 at 11:35 AM, revealed after DON #2 left the facility, the SDC went to DON #3 to inform her of the Unlicensed Graduate Nurse not having a license and that her ninety (90) days were up. Interview with DON #3, on 03/29/16 at 10:55 AM, revealed she could not answer to all of the care that was provided by the Unlicensed Graduate Nurse. DON #3 stated she knew she worked since November 2015. DON #3 stated she honestly thought the Unlicensed Graduate Nurse was an LPN. DON #3 stated the Staff Development Coordinator and LPN #10 approached her and informed her the Unlicensed Graduate Nurse did not have a license to work, nor had she taken her boards. According to DON #3, she then went to Human Resources. Human Resources stated DON #2 had informed her the Unlicensed Graduate Nurse could work for ninety (90) days on a temporary license. DON #3 stated she then went to the Kentucky Board of Nursing web site and could not find a license for the Unlicensed Graduate Nurse. DON #3 then stated she interviewed the Unlicensed Graduate Nurse who informed her she had not completed boards, nor did she have a provisional license. The Unlicensed Graduate Nurse stated the Kentucky Board of Nursing was working on an issue with her background check. Further interview revealed the Unlicensed Graduate Nurse gave DON #3 the number to the legal department at the Kentucky Board of Nursing and they stated there was a drug and alcohol situation documented on her background check and the Unlicensed Graduate Nurse could not sit for boards. DON #3 stated the Legal Department at the KBN had to review all of her documents and had to develop an agreement regarding monthly drug testing for a year before the provisional license could be issued to the Unlicensed Graduate Nurse. The legal department stated the Unlicensed Graduate Nurse could work as a Certified Nursing Assistant (CNA), but not a nurse. She could not complete treatments, medication pass or assessments. DON #3 stated when she was the Unit Manager on the East Unit, as far as she knew the Unlicensed Graduate Nurse did not work on her unit. It was common knowledge that she was a nurse and completed nursing tasks. DON #3 stated she then told the Unlicensed Graduate Nurse that she could not work until she informed the Administrator. She stated the Administrator then talked to the Unlicensed Graduate Nurse and decided to let the Unlicensed Graduate Nurse work as an assistant to the CNA. After review by DON #3 of the Unlicensed Graduate Nurse's employee file, it was determined the Unlicensed Graduate Nurse had applied to the facility as an LPN. Interview with the Administrator #3, on 03/29/16 at 10:45 AM, revealed DON #2 did not make her aware that the Unlicensed Graduate Nurse was actually not a nurse. DON #1 who was responsible for hiring at the time led the Human Resource (HR) Department to believe that they could hire a non-licensed staff member for ninety (90) days. Administrator #3 stated she found out about the Unlicensed Graduate Nurse not having a provisional license on 03/11/16 by DON #3. She stated HR was asking DON #3 about the status of the Unlicensed Graduate Nurse's license. DON #3 then called the Kentucky Board of Nursing to validate if someone could work without a provisional license and the answer was No, so they took the Unlicensed Graduate Nurse off the floor as a nurse immediately on 03/11/16. Administrator #3 stated she was not sure of all of the services or assignments the Unlicensed Graduate Nurse completed. Administrator #3 stated she informed the Unlicensed Graduate Nurse that working as a nurse could jeopardize her ability to become a nurse. Interview with the Nurse Consultant, on 03/29/16 at 5:32 PM, revealed the company she worked for took over on 12/01/15 and to her understanding there were people who went through the employee files and checked for job descriptions, drug screens and background checks. Further interview with the Nurse Consultant, on 03/30/16 at 8:30 AM, revealed prior to 12/01/15 and prior to the hire of the Unlicensed Graduate Nurse the new corporation had completed licensure checks on all licensed staff. After that the facility was responsible to check licensure on any new staff licensed. Interview with the Corporate Team who assisted with acquisition (change over from one corporation to another corporation), on 03/30/16 at 4:10 PM, revealed the process was for the corporation to request an employee census of basic information, then load the information into the corporations computer. She then would use this information to complete credentialing including licensure checks. There was no concerns identified. The Corporate Team then would reconcile with any information found within thirty (30) days. She stated they were in the facility throughout November of 2015. There was HR training with a webinar. The process for educating the staff to knew policies and procedures was not an immediate process, because it was a blending of the old corporation with the new corporation. The facility took the following actions to remove the Immediate Jeopardy: 1. On 03/14/16, DON #3 removed the stakeholder (Unlicensed Graduate Nurse), who did not have a provisional, from the LPNA role. On 03/28/16, the Administrator suspended the stakeholder. 2. The Corporate Care Consultants reviewed and validated thirty-one (31) stakeholders working as licensed nurses on 03/28/16; and, seven (7) were validated on 04/01/16 via the Kentucky Board of Nursing (KBN) online verification report. No stakeholder was found to be working without a valid nursing license. 3. The Corporate Care Consultants reviewed all current residents medical records that were assigned to the non-licensed stakeholder. Forty-one (41) charts were reviewed on 03/31/16; and, nine (9) were reviewed on 04/01/16. Of the fifty (50) charts reviewed, no care issues were noted related to the non-licensed stakeholder. The facility identified twenty-one (21) clinical records that had missing credentials. The DON and Nurse Managers began education addressing appropriate signage of the medical record including credentials for the unlicensed nursee. The facility implemented a Medical Record Review Process on 04/04/16 by the DON. The DON and/or Nurse Managers would review the medical record (physician's orders [REDACTED]. Five (5) percent of the current census would be reviewed for physician orders, nurses's notes and assessments in the daily clinical meeting (Monday-Friday) for two (2) weeks; if compliance was maintained, audits would decrease to 5% three (3) times a week for four (4) weeks, and then monthly for three (3) months. 4. The Consultants provided education to the DON and Nurse Managers on 04/01/16, on the process of auditing of the medical record(s). The education consisted of: legible signature to include credentials; physician orders [REDACTED]. The Nurse Managers, Staff Developed Coordinator (SDC), and DON #3 provided the above education to all licensed nursing stakeholders 04/01/16 through 04/04/16. Any licensed stakeholder that had not received the education by 04/04/16 would be issued a certified letter with the training material. Education and Post Education Competency would be completed by the DON and/or Nurse Managers in person and/or via phone for licensed nurses from 04/01/16 through 04/04/16. When conducting the Post Education Competency via phone, the SDC and/or Nurse Managers would ask the examination questions and document the licensed nurse's response on the examination. The SDC and/or Nurse Managers would follow up with the nurse in person to go over the training material verbally and the stakeholder would complete a written examination with the stakeholder's signature. The SDC and/or Nurse Managers would provide the training to a new stakeholder through the orientation program. The SDC and/or Nurse Manager would provide the Administrator and DON with a verbal progress report of the new stakeholder's performance and/or education skills needed during the orientation process. 5. The Human Resources (HR) Personnel, Receptionist, or Nurse Managers would conduct a KBN online validation report during the interview process for stakeholders applying for a licensed position and when a licensed position status change had occurred. The validation would be printed, reviewed, and signed by the DON, HR Personnel, Receptionist, or Nurse Manager as proof of validation status. The Administrator would conduct the final review. The HR Personnel, Receptionist, or Nurse Managers would conduct monthly and/or needed licensure review via KBN online validation report to ensure licenses were valid for three (3) months. If compliance is maintained, audits would be reduced to quarterly for two (2) quarters then annually thereafter. The Corporate Care Consultants would review completed KBN online validation reports daily (Monday-Friday) for four (4) weeks. If compliance is maintained, audits would decrease to two (2) times per week for four (4) weeks to ensure the validation process was completed. The audits would decrease to monthly for three (3) months during their facility visits. 6. The Corporate Care Consultants, Regional Vice President, and/or HR Advisory Personnel would provide ongoing education as needed for new administrative staff. The consultants would provide facility visits a minimum of five (5) days per week for two (2) weeks to review action plan and assist with education needs. If compliance was maintained, the visits would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD. RADCLIFF, KY 40160**

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 0499 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 23) decrease to three (3) per week for eight (8) weeks, then a minimum of monthly thereafter. 7. An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 03/28/16 to review the survey findings and the facility's licensure validation process. Those in attendance included the Administrator, DON, HR Director, Unit Nurse Managers, and the Medical Director. On 03/30/16, a second Ad Hoc QAPI meeting was conducted with the Administrator, DON, Medical Director, Social Services, SDC, and Unit Managers to review policies and procedures related to the hiring and orientation process, and the supervision of LPNAs, RNAs, and student nurses. No changes were made to the hiring process or the Orientation Checklist. The Orientation Checklist for licensed stakeholders would be utilized for LPNAs and RNAs with direct supervision. A new Supervision Policy was created for LPNAs, RNAs, and student nurses on 03/30/16 during the QAPI meeting with the approval of the Medical Director. In addition, the Physical Order/Supplies and Scheduling of Medical Appointments Process was reviewed with no changes. A third Ad Hoc meeting was held on 04/01/16 with the Administrator, DON, and Medical Director via phone to review all recent survey citations and action plans. On 04/04/16, the Administrator and DON met with the Medical Director for overview of the survey findings: F281-discussed the incident with a non-licensed nurse related to Professional Standards with implementation of Licensure Validation Process; F282-discussion of oversight to ensure the care plan was followed; F309-discussed the failure to follow physician orders, provision of supplies, and scheduling of medical appointments; F490-reviewed the role of the Administrator to provide oversight for facility operations. Guidance and oversight would be provided by the Regional Vice President. The Administrator would review all audits and conduct observation rounds. F499- recapped the process for preventing non-licensed staff from working as licensed staff by completing the Licensure Validation Process. F514-reviewed education provided to maintain compliance in the deficient areas, including a post examination. Also reviewed the audit system/tools implemented to monitor processes. Audits would be discussed in the morning meeting, weekly QAPI and monthly QAPI. The IDT team will meet weekly times four (4) weeks to review all audit findings. If compliance was maintained, will reduce to monthly. 8. Order/Supply Process: Licensed nurse (s) would place physician orders [REDACTED]. Medical appointments would be scheduled as ordered, including transportation and logged on the monthly calendar. Unit Managers (Nurse Mangers) would review admission/readmission and/or new telephone orders and discuss in the morning clinical meetings (Monday-Friday). Ordered supplies would be discussed in the morning clinical meeting to ensure supplies were available for the resident (s). If the supplies cannot be obtained, a licensed nurse would contact the resident's physician for alternative orders until the supplies were available. 9. The Regional Vice President reviewed administrative duties that included: hiring process, licensure validation, facility oversight, role of the Administrator-in-training, and the job description with the Administrator on 04/04/16. The Regional Vice President will conduct weekly telephone calls with the Administrator for four (4) weeks to discuss current action plans and audit findings. If the facility's operations and oversight meet the residents' needs, the conference call would decrease to monthly for three (3) months, and then quarterly thereafter. If non-compliance is noted, the Vice President would modify oversight as needed to meet the needs of the residents. The State Agency validated removal of the Immediate Jeopardy on 04/07/16 as follows: 1. Review of the Stakeholder Suspension Form revealed the unlicensed stakeholder was suspended on 03/28/16 by the Administrator. Review of a written statement from DON #3 revealed she removed the employee from any licensed nurse duties on 03/14/16. Interview with the DON, on 04/06/16 at 3:29 PM and Administrator, on 04/06/16 at 5:03 PM, validated the stakeholder was suspended on 03/28/16. 2. Review of the facility's licensed staff roster revealed thirty-eight (38) nurses were employed as of 04/06/16. All thirty-eight (38) nurses had a KBN validation report validating they had a valid nursing license. Interview with Corporate Care Consultants #2, and #3, on 04/07/16 at 1:03 AM, revealed the facility had obtained validation of license for all nurses employed by the facility. Received validation reports from the KBN and no stakeholder was working without a license. 3. Review of the medical record review audit sheet revealed forty-three (43) records were reviewed with no problem identified. The audits were conducted on 03/31/16 and 04/01/16 by three (3) Corporate Care Consultants. Interview with Corporate Care Consultants #2 and #3, on 04/07/16 at 10:03 AM, revealed the review of the clinical record found no resident experienced a negative outcome related to the non-licensed stakeholder. The audit did find the nurses were not always signing with credentials. Review of the Medical Record Audit sheets, dated 04/01/16 through 04/06/16, revealed eight (8) to ten (10) residents' records were audited daily by the DON, Nurse Managers, and Corporate Care Consultants. Interview with Consultants #2 and #3, on 04/07/16 at 10:03 AM, West Wing Unit Manager, on 04/06/16 at 3:10 PM, and DON #3, on 04/06/16 at 3:29 PM, revealed medical record audits were being conducted for 5% of the resident census to ensure physician orders [REDACTED]. 4. Review of the training records revealed DON #3, East Unit Manager and West Unit Manager revealed they received training on 04/01/16 on how to audit the medical record and education on legible signatures with credentials, physician orders, supervision of LPNAs, RNAs, and nursing students, following care plans, and scheduling appointments. A post test was taken with the DON and managers scoring 100%. Interview with DON #3, on 04/06/16 at 3:29 PM, revealed she had received the education on the topic above. She then provided training to all licensed nursing stakeholders. She was trained on how to conduct the medical record audits and was involved in conducting those audits. Interview with the East Wing Unit Manager, on 04/06/16 at 11:25 AM, revealed she had been trained to do the medical record audits; however, she had not conducted the audits to date. She revealed she had only been in this position for three (3) weeks and was still learning. Further interview revealed she validated she had received training on physician orders, care plans, scheduling of appointments, documentation to be legible and to include credentials; and, supervision of LPNAs and RNAs. She had not conducted training of the nurses. Interview with the West Wing Unit Manager, on 04/06/16 at 3:10 PM, revealed she had been trained on how to conduct audits of the medical record and had conducted a few over the weekend. She validated she received training on physician orders, documentation in the medical record to be legible with credentials, care plans, scheduling of appointments, physician orders, and supervision of LPNAs and RNAs. She had not conducted training of the nurses. Review of the training records and post test revealed thirty-three (33) licensed nurses and four (4) Certified Medication Technicians were trained on documentation in the medical record that was complete, legible and included credentials. In addition, physician orders, care plans, scheduled appointments, and supervision of LPNAs and RNAs was also reviewed by the survey team. All had passed the post test with a score of 100. Record review revealed five (5) stakeholders had not received the training as of 04/04/16. Certified letters were sent on 04/04/16 to those employees. Copies of the letters were reviewed and the certified mail receipts. A letter written by the Admini
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, it was determined the facility failed to ensure the clinical records were accurate in regards to unlicensed staff documenting with legal credentials for one (1) of twelve (12) sampled residents (Resident #5); and, three (3) of thirteen (13) unsampled residents, (Unsampled Residents B, E, and J). In addition, the facility failed to ensure Resident #5's records were documented completely and accurately as it pertained to a [DEVICE] Assisted Closure (V.A.C.) and Negative-pressure Wound Therapy (NPWT) dressing changes on Tuesdays, Thursdays and Saturdays. On 11/30/15 the facility hired an Unlicensed Graduate Nurse to function as a Practical Nurse Applicant. The Unlicensed Graduate Nurse documented the care provided to residents including clinical assessments, medication administration, treatments, diabetic care that included insulin injections, and [MEDICATION NAME] flushes for an intravenous (IV) line as a Practical Nurse Applicant.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0514

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 24)

The facility's failure to have an effective system in place to ensure clinical assessments, medication administration, treatments, diabetic care and IV medications were documented by qualified personnel who were legally credentialed placed residents at risk for severe injury, harm, impairment or death.

The facility provided an acceptable Allegation of Compliance (AOC) on 04/04/16, which alleged removal of Immediate Jeopardy on 04/05/16. The State Survey Agency (SSA) verified the Immediate Jeopardy was not removed on 04/05/16 as alleged, but on 04/07/16 (facility allowed a nurse to return to work without training on 04/06/16) prior to exit on 04/08/16. The scope and severity was lowered to an E while the facility develops and implements the plan of correction and the Quality Assurance monitors for effectiveness of the systemic changes.

The findings include:

Review of the facility's Charting and Documentation Policy, no date given, revealed documenting of procedures and treatments should include care-specific details and shall include at a minimum the signature and title of the individual documenting.

Interview with Licensed Practical Nurse (LPN) #10, on 03/29/16 at 4:10 PM, revealed when a nurse signed a document he/she was to place LPN or Registered Nurse (RN) credentials after their name on any documentation.

1. Review of Resident #5's, admission orders [REDACTED].

Review of Unsampled Resident B's Daily Skilled Nurses Notes, dated 03/06/16 at 5:00 PM, 03/08/16 at 5:40 PM, 03/09/16 at 9:45 PM; and, on 03/10/16 at 9:45 PM, revealed the Unlicensed Graduate Nurse documented her name with the credential of LPN (although she was not a licensed nurse). Review of Unsampled Resident B's physician's orders [REDACTED].

Review of Unsampled Resident E's Nursing Admission Information, dated 02/16/16, revealed the Unlicensed Graduate Nurse signed she completed the assessment with no credentials documented. Review of Unsampled Resident E's Physician order [REDACTED]. All orders were signed with no credentials. Review of Unsampled Resident E's Daily Skilled Nurses Notes, dated 03/10/16 at 10:00 PM, revealed the Unlicensed Graduate Nurse documented her name with the credential of LPN (though she was not a licensed nurse).

Review of Unsampled Resident J's admission orders [REDACTED]. Review of Unsampled Resident J's Daily Skilled Nurses Notes, dated 01/31/16 at 6:00 PM, revealed the Unlicensed Graduate Nurse signed her signature with no credentials.

Interview via telephone with Director of Nursing (DON) #2, on 03/31/16 at 9:28 AM, revealed she did not check documentation or complete record reviews of random residents' records. DON #2 stated she was not aware the Unlicensed Graduate Nurse was signing LPN after her name and not documenting any credentials on some records. DON #2 stated it was the Unit Managers' responsibility to ensure the staff's documentation contained the appropriate signatures.

Interview with DON #3, on 03/29/16 at 10:55 AM, revealed she was not aware the Unlicensed Graduate Nurse's employee badge had LPN after her name instead of LPNA (however, she was not a LPNA, as she had not applied for a license). Nor was DON #3 aware the Unlicensed Graduate Nurse documented LPN in the clinical records. DON #3 stated the nursing staff was to sign their title when completing documents. If the nurse did not document credentials legally then the document was not valid.

Interview with Unit Manager #2 of the West Hall, on 03/30/16 at 3:20 PM, revealed when she reviewed the telephone orders, she would look to see that the nurse signed her signature and had placed her credentials legibly. The nursing staff should be documenting their credentials. If a nurse was a graduate nurse with no license, you should not see any credentials behind their name. Unit Manager #2 of the West Hall stated after she reviewed some of the records she identified that the Unlicensed Graduate Nurse worked a lot and should not have worked at all.

Interview with DON #3, on 03/28/16 at 12:03 PM, revealed to her knowledge there was no evidence that a nurse had co-signed behind the Unlicensed Graduate Nurse to validate direct supervision of the task provided by the graduate nurse.

2. Review of the facility's Charting and Documentation Policy, no date given, revealed services provided to the resident, or any changes in the resident's medical condition, would be documented in the resident's medical record. Incidents, accidents, or changes in the resident's condition must be recorded. The documentation of the procedure and treatment should include care-specific details and should include at a minimum the date and time the procedure/treatment was provided; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment and whether the resident refused the procedure/treatment.

Review of Resident #5's Treatment Administration Record (TAR) for the month of February 2016, revealed on 02/06/16, 02/09/16 and 02/13/16 there was no documented evidence from the nursing staff that the wound V.A.C. was changed.

Interview with the Unlicensed Graduate Nurse, on 03/17/16 at 3:21 PM, revealed after reviewing the TAR and the documentation, it appeared the wound V.A.C. dressing had not been completed. According to the Unlicensed Graduate Nurse, if something was not documented, then it was not done. The Unlicensed Graduate Nurse said she would have to say the record was not complete because the documentation had not been completed.

Interview with the facility's Wound Nurse, on 03/17/16 at 3:59 PM, revealed no nurse expressed to her that they could not complete the dressing change or that they did not know how to do the dressing. According to the Wound Nurse, she did not look to see if the wound V.A.C. had been changed out timely. When the Wound Nurse reviewed the TAR documentation, she stated if the nurses did not document that they completed a task, then the treatment was not done.

Interview with Director of Nursing (DON) #3, on 03/17/16 at 5:50 PM, revealed after reviewing Resident #5's TAR documentation, she could see gaps. The DON stated she had not seen any documentation until 02/13/16. If the TAR was not signed then the wound V.A.C. was not changed and this was not a complete record; however, she had not identified this as a concern.

The facility took the following actions to remove the Immediate Jeopardy:

1. On 03/14/16, DON #3 removed the stakeholder (Unlicensed Graduate Nurse), who did not have a provisional, from the LPNA role. On 03/28/16, the Administrator suspended the stakeholder.

2. The Corporate Care Consultants reviewed and validated thirty-one (31) stakeholders working as licensed nurses on 03/28/16; and, seven (7) were validated on 04/01/16 via the Kentucky Board of Nursing (KBN) online verification report. No stakeholder was found to be working without a valid nursing license.

3. The Corporate Care Consultants reviewed all current residents medical records that were assigned to the non-licensed stakeholder. Forty-one (41) charts were reviewed on 03/31/16; and, nine (9) were reviewed on 04/01/16. Of the fifty (50) charts reviewed, no care issues were noted related to the non-licensed stakeholder. The facility identified twenty-one (21) clinical records that had missing credentials. The DON and Nurse Managers began education addressing appropriate signage of the medical record including credentials for the unlicensed nursee.

The facility implemented a Medical Record Review Process on 04/04/16 by the DON. The DON and/or Nurse Managers would review
the medical record (physician's orders [REDACTED].

Five (5) percent of the current census would be reviewed for physician orders, nurses's notes and assessments in the daily clinical meeting (Monday-Friday) for two (2) weeks; if compliance was maintained, audits would decrease to 5% three (3) times a week for four (4) weeks, and then monthly for three (3) months.

4. The Consultants provided education to the DON and Nurse Managers on 04/01/16, on the process of auditing of the medical record(s). The education consisted of: legible signature to include credentials; physician orders [REDACTED].

The Nurse Managers, Staff Developed Coordinator (SDC), and DON #3 provided the above education to all licensed nursing stakeholders 04/01/16 through 04/04/16.

Any licensed stakeholder that had not received the education by 04/04/16 would be issued a certified letter with the training material. Education and Post Education Competency would be completed by the DON and/or Nurse Managers in person and/or via phone for licensed nurses from 04/01/16 through 04/04/16. When conducting the Post Education Competency via phone, the SDC and/or Nurse Managers would ask the examination questions and document the licensed nurse's response on the examination. The SDC and/or Nurse Managers would follow up with the nurse in person to go over the training material verbally and the stakeholder would complete a written examination with the stakeholder's signature. The SDC and/or Nurse Managers would provide the training to a new stakeholder through the orientation program. The SDC and/or Nurse Manager would provide the Administrator and DON with a verbal progress report of the new stakeholder's performance and/or education skills needed during the orientation process.

5. The Human Resources (HR) Personnel, Receptionist, or Nurse Managers would conduct a KBN online validation report during the interview process for stakeholders applying for a licensed position and when a licensed position status change had occurred. The validation would be printed, reviewed, and signed by the DON, HR Personnel, Receptionist, or Nurse Manager as proof of validation status. The Administrator would conduct the final review.

The HR Personnel, Receptionist, or Nurse Managers would conduct monthly and/or needed licensure review via KBN online

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD. RADCLIFF, KY 40160**

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 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 25) validation report to ensure licenses were valid for three (3) months. If compliance is maintained, audits would be reduced to quarterly for two (2) quarters then annually thereafter. The Corporate Care Consultants would review completed KBN online validation reports daily (Monday-Friday) for four (4) weeks. If compliance is maintained, audits would decrease to two (2) times per week for four (4) weeks to ensure the validation process was completed. The audits would decrease to monthly for three (3) months during their facility visits. 6. The Corporate Care Consultants, Regional Vice President, and/or HR Advisory Personnel would provide ongoing education as needed for new administrative staff. The consultants would provide facility visits a minimum of five (5) days per week for two (2) weeks to review action plan and assist with education needs. If compliance was maintained, the visits would decrease to three (3) per week for eight (8) weeks, then a minimum of monthly thereafter. 7. An Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted on 03/28/16 to review the survey findings and the facility's licensure validation process. Those in attendance included the Administrator, DON, HR Director, Unit Nurse Managers, and the Medical Director. On 03/30/16, a second Ad Hoc QAPI meeting was conducted with the Administrator, DON, Medical Director, Social Services, SDC, and Unit Managers to review policies and procedures related to the hiring and orientation process, and the supervision of LPNAs, RNAs, and student nurses. No changes were made to the hiring process or the Orientation Checklist. The Orientation Checklist for licensed stakeholders would be utilized for LPNAs and RNAs with direct supervision. A new Supervision Policy was created for LPNAs, RNAs, and student nurses on 03/30/16 during the QAPI meeting with the approval of the Medical Director. In addition, the Physical Order/Supplies and Scheduling of Medical Appointments Process was reviewed with no changes. A third Ad Hoc meeting was held on 04/01/16 with the Administrator, DON, and Medical Director via phone to review all recent survey citations and action plans. On 04/04/16, the Administrator and DON met with the Medical Director for overview of the survey findings: F281-discussed the incident with a non-licensed nurse related to Professional Standards with implementation of Licensure Validation Process; F282-discussion of oversight to ensure the care plan was followed; F309-discussed the failure to follow physician orders, provision of supplies, and scheduling of medical appointments; F490-reviewed the role of the Administrator to provide oversight for facility operations. Guidance and oversight would be provided by the Regional Vice President. The Administrator would review all audits and conduct observation rounds. F499- recapped the process for preventing non-licensed staff from working as licensed staff by completing the Licensure Validation Process. F514-reviewed education provided to maintain compliance in the deficient areas, including a post examination. Also reviewed the audit system/tools implemented to monitor processes. Audits would be discussed in the morning meeting, weekly QAPI and monthly QAPI. The IDT team will meet weekly times four (4) weeks to review all audit findings. If compliance was maintained, will reduce to monthly. 8. Order/Supply Process: Licensed nurse (s) would place physician orders [REDACTED]. Medical appointments would be scheduled as ordered, including transportation and logged on the monthly calendar. Unit Managers (Nurse Mangers) would review admission/readmission and/or new telephone orders and discuss in the morning clinical meetings (Monday-Friday). Ordered supplies would be discussed in the morning clinical meeting to ensure supplies were available for the resident (s). If the supplies cannot be obtained, a licensed nurse would contact the resident's physician for alternative orders until the supplies were available. 9. The Regional Vice President reviewed administrative duties that included: hiring process, licensure validation, facility oversight, role of the Administrator-in-training, and the job description with the Administrator on 04/04/16. The Regional Vice President will conduct weekly telephone calls with the Administrator for four (4) weeks to discuss current action plans and audit findings. If the facility's operations and oversight meet the residents' needs, the conference call would decrease to monthly for three (3) months, and then quarterly thereafter. If non-compliance is noted, the Vice President would modify oversight as needed to meet the needs of the residents. The State Agency validated removal of the Immediate Jeopardy on 04/07/16 as follows: 1. Review of the Stakeholder Suspension Form revealed the unlicensed stakeholder was suspended on 03/28/16 by the Administrator. Review of a written statement from DON #3 revealed she removed the employee from any licensed nurse duties on 03/14/16. Interview with the DON, on 04/06/16 at 3:29 PM and Administrator, on 04/06/16 at 5:03 PM, validated the stakeholder was suspended on 03/28/16. 2. Review of the facility's licensed staff roster revealed thirty-eight (38) nurses were employed as of 04/06/16. All thirty-eight (38) nurses had a KBN validation report validating they had a valid nursing license. Interview with Corporate Care Consultants #2, and #3, on 04/07/16 at 1:03 AM, revealed the facility had obtained validation of license for all nurses employed by the facility. Received validation reports from the KBN and no stakeholder was working without a license. 3. Review of the medical record review audit sheet revealed forty-three (43) records were reviewed with no problem identified. The audits were conducted on 03/31/16 and 04/01/16 by three (3) Corporate Care Consultants. Interview with Corporate Care Consultants #2 and #3, on 04/07/16 at 10:03 AM, revealed the review of the clinical record found no resident experienced a negative outcome related to the non-licensed stakeholder. The audit did find the nurses were not always signing with credentials. Review of the Medical Record Audit sheets, dated 04/01/16 through 04/06/16, revealed eight (8) to ten (10) residents' records were audited daily by the DON, Nurse Managers, and Corporate Care Consultants. Interview with Consultants #2 and #3, on 04/07/16 at 10:03 AM, West Wing Unit Manager, on 04/06/16 at 3:10 PM, and DON #3, on 04/06/16 at 3:29 PM, revealed medical record audits were being conducted for 5% of the resident census to ensure physician orders [REDACTED]. 4. Review of the training records revealed DON #3, East Unit Manager and West Unit Manager revealed they received training on 04/01/16 on how to audit the medical record and education on legible signatures with credentials, physician orders, supervision of LPNAs, RNAs, and nursing students, following care plans, and scheduling appointments. A post test was taken with the DON and managers scoring 100%. Interview with DON #3, on 04/06/16 at 3:29 PM, revealed she had received the education on the topic above. She then provided training to all licensed nursing stakeholders. She was trained on how to conduct the medical record audits and was involved in conducting those audits. Interview with the East Wing Unit Manager, on 04/06/16 at 11:25 AM, revealed she had been trained to do the medical record audits; however, she had not conducted the audits to date. She revealed she had only been in this position for three (3) weeks and was still learning. Further interview revealed she validated she had received training on physician orders, care plans, scheduling of appointments, documentation to be legible and to include credentials; and, supervision of LPNAs and RNAs. She had not conducted training of the nurses. Interview with the West Wing Unit Manager, on 04/06/16 at 3:10 PM, revealed she had been trained on how to conduct audits of the medical record and had conducted a few over the weekend. She validated she received training on physician orders, documentation in the medical record to be legible with credentials, care plans, scheduling of appointments, physician orders, and supervision of LPNAs and RNAs. She had not conducted training of the nurses. Review of the training records and post test revealed thirty-three (33) licensed nurses and four (4) Certified Medication Technicians were trained on documentation in the medical record that was complete, legible and included credentials. In addition, physician orders, care plans, scheduled appointments, and supervision of LPNAs and RNAs was also reviewed by the survey team. All had passed the post test with a score of 100. Record review revealed five (5) stakeholders had not received the training as of 04/04/16. Certified letters were sent on 04/04/16 to those employees. Copies of the letters were reviewed and the certified mail receipts. A letter written by the Administrator, dated 04/04/16, accompanied the training material. In the letter, the Administrator instructed the licensed nurses they must review the enclosed education material and complete a post test before returning to work. The stakeholder was instructed to turn in the post test and sign the training roster before returning to the facility for a scheduled shift. Validation interviews were conducted on 04/06/16 with LPN #12 at 10:46 AM, LPN #9 at 11:08 AM, LPN #6 at 1:46 PM, LPN #11 at 4:23 PM, and LPN #3 at 4:38 PM, revealed they had received the training and taken the post test. Each nurse had good knowledge of the training topics. Interview with LPN #8, on 04/06/16 at 11:42 AM revealed she needed to complete the training. She stated she had been informed of a certified letter, but she had not been to the post office to pick up the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185180**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **04/08/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT NORTH HARDIN REHAB & WELLN	**599 ROGERSVILLE RD.** **RADCLIFF, KY 40160**

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 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 26) certified letter. Therefore, she did not know what the letter contained. She stated she started her work shift today at 6:30 AM and nobody had informed her that she had to complete the training before caring for residents. She stated the Unit Manager had not said anything to her and she had not received any training over the phone. Interview with the West Unit Manager, on 04/16/16 at 11:58 AM, revealed she was unaware the nurse had not received the training. She stated she did realize the DON had not provided training over the phone until the nurse could receive the training in person and taken the post test. Interview with DON #3, on 04/06/16 at 12:06 AM and 12:12 PM, revealed she had called LPN #8 twice and never could reach her. She assumed the nurse had received the certified letter with the training material. She stated she had reviewed the working schedule and didn't realize the nurse was working (that day). She stated it was an oversight and she or the Unit Manager realized she had not been trained. Verification of the nurse's training with a post test was provided to the surveyor on 04/16/16 at 12:10 PM. 5. Review of a newly hired nurse, on 03/29/16, validation check revealed the facility conducted a KBN online validation report on 03/29/16 that revealed the nurse had a valid license. The validation report was reviewed by the HR Personnel, DON #3, Administrator, and Corporate Consultant as indicated by their signatures on the validation report. Review of the training revealed the newly hired nurse had received education on the topics that were included in the AOC. Interview with the HR Director, on 04/06/16 at 4:05 PM, revealed she had received training on the validation process. She stated once an application was received and before an offer letter was sent, she would conduct a validation check with the KBN. After the offer letter was sent another check was conducted at the KBN for abuse registry and a Criminal Background Check would be conducted. She stated she would review the validation report from the KBN then the DON, and the Administrator would do the final check. She stated she assisted with the validation of license for the facility's nurses. The Corporate Consultant signed off as reviewing the hire packet for the newly hired nurse on 04/01/16. The consultant reviewed and signed off on the nurses who are in the interviewing process. 6. Interview with Corporate Care Consultants #2 and #3 and the Special Project Consultant, on 04/07/16 at 10:03 AM revealed they would be providing oversight and assistance to the facility for some time. They stated they have been at the facility daily including some weekend days to conduct audits and assist with educational needs. Consultants #1, #2, and #3 would be at the facility Monday-Friday for several weeks to review action plans, audits, and training before they decrease to three (3) times a week. Once they identify any non-compliance, re-education would be conducted. They were looking at the clinical matrix, and the development of education topics that may include other disciplines beside nursing. The facility did not have a new Administrator in training at the time of the survey. A consultant will attend the clinical meetings to ensure a meeting is held as stated and topics discussed. The consultants reviewed the audits to ensure they were being conducted correctly and to see if there were any training issues. They were in the process of developing an afternoon meeting to recap the day. 7. Review of the QAPI signature sheet, dated 03/28/16, revealed the survey findings were discussed. The Medical Director, Administrator, DON, Corporate Consultant #1, and five (5) other committee members. On 03/30/16, an Ad Hoc meeting was held to discuss the Immediate Jeopardy findings. The Administrator, DON, Unit Managers and SDC was present with the Medical Director via phone conference. Additional Ad Hoc QAPI meetings were held on 04/01/16, 04/04/16 and 04/06/16. Interview with the Administrator, on 04/06/16 at 5:03 PM, validated the above QAPI meetings were held. She stated she conducted the meetings and the Medical Director was either present in person or via phone. She stated the frequent QAPI meetings were to review what process had been changed and were they effective. The committee reviewed the audits. She stated the audits were also reviewed in the morning meetings before they were reviewed in the QAPI meetings. She stated she will conduct a weekly QAPI meeting for the next month. In addition, the IDT meet weekly to review the audits. Interview with the Medical Director, on 04/06/16 at 4:48 PM, revealed he had been involved in the whole process since the beginning of the Immediate Jeopardy. The facility's Administrator provided him an overview of the survey findings and requested his input in the corrective plans. He reviewed the policies and validation process and discussed the physician orders [REDACTED]. 8. Review of Unsampled Residents L's and M's record revealed physician orders [REDACTED]. Review of the appointment calendar revealed the scheduled appointment had been placed in the calendar with transportation obtained. Review of the appointment calendars for the East and West Units and audits revealed no missed appointments. 9. Review of the education provided by the Regional Vice President to the Administrator and DON #3, on 04/04/16, revealed the training was on F490 and review of the Administrator's job description. A telephone interview with the Regional Vice President, on 04/07/16 at 9:54 AM, revealed he validated the training provided to the facility's Administrator. He stated he reviewed the role of the Administrator and responsibilities related to the hiring process, licensure validation, facility oversight, and Administrator in training. He stated the Administrator would provide oversight through observation rounds and review of clinical meeting findings. He stated he would conduct weekly telephone conference calls with the Administrator to discuss current corrective action plans, audit findings, facility operation, and oversight met the residents' needs. He would conduct the weekly calls for four (4) weeks and then decrease to monthly times three (3) months, then quarterly.