HEBERT
HEALTH★CENTER
A Nursing and Rehabilitation Center

An American Senior Living Community

January 25, 2012

Arthur Pullano
Department of Health
Facilities Regulation
3 Capitol Hill
Providence, RI 02908

Dear Arthur,

Enclosed is our completed 2567 for your review from an inspection conducted by your team on 12/19/2011 with an exit on 12/22/2011 and a continuation revisit on 1/6/2012.

Should you have any questions please give me a call.

Sincerely,

Alan J. Barroso RN, BS, ALRA, NHA

180 Log Road, Smithfield, RI 02917-1518
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415049	A. BUILDING _____ B. WING _____	C 01/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEBERT NURSING HOME	180 LOG ROAD SMITHFIELD, RI 02917

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F 000	INITIAL COMMENTS A Complaint Investigation survey was conducted at this facility. An extended survey was conducted. State and Federal deficiencies were cited along with Substandard Quality of Care/Immediate Jeopardy.	F 000	The filing of the plan of correction does not constitute an admission that the deficiencies alleged did in fact exist or that any of the statements or facts cited occurred; rather this POC is filed as evidence of the facility's commitment to quality resident care in full compliance with State and Federal Regulations. The facility reserves the right to challenge by legal proceedings the alleged deficiencies as well as the alleged statements, findings, facts and conclusions that form the basis of the allegations.	
F 224 SS=K	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, it was determined the facility failed to ensure that residents are free from neglect for 2 of 12 sample residents [ID#(s) 1 and 7]. Findings are as follows: 1. Resident ID #1 was re-admitted to the facility on 1/31/2011. She has lived in the facility since 8/31/2007 and has a diagnosis of Dementia. A review of the 10/13/2011 quarterly Minimum Data Set reveals a BIMS (Brief Interview for Mental Status) score of 4 out of 15 indicating severe cognitive impairment. The resident is incontinent and is dependent on staff for personal hygiene. A review of information attached to a complaint of alleged abuse by family revealed numerous accounts by staff (nursing assistants and nurses)	F 224	**F224** **With regard to resident ID #1:** a) Resident's daughters have not been in the facility since 12/1/2011. b) All staff was reeducated as to the definitions of abuse, neglect and mistreatment as well as reporting timeframes and procedures. This task was completed in full on 12/27/2011. c) All staff identified as reporting allegations of abuse outside the required time was counseled verbally and in writing. This task was complete on 12/29/2011. d) A Supervisor-to-Administrator report has been developed and implemented. Each shift supervisor speaks with all staff on duty while collecting report to determine if any reportable event occurred during the shift. Administrative staff reviews the report daily to determine if a concern requiring report and/or investigation occurred. The Administrator is responsible to ensure ongoing compliance.	Provision 1/26/12 12/27/11 12/29/11

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

Alice Bruno RN Administrator 1/25/12

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

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F 224	Continued From page 1 reporting concerns regarding what they considered to be inappropriate touching and inspection of the resident's private areas by both of her daughters. This information included "Journal Entries" written by a representative from the Alliance for Better Long Term Care (Alliance), an Incident Report and Witness Statements from the local police department and written statements by witnesses. All above staff reported they had reported these incidents to their supervisors, including the Director of Nurses and the Administrator. A review of nurses' notes revealed the following: 1. On 8/10 and 9/13/2011 the resident's daughter(s) inspected her peri (genital) area. 2. On 10/16/2011 the resident choked and spit out her medications when her daughter took the medication cup from the nurse and put the medications into the resident's mouth. 3. On 11/20/2011 a nursing assistant informed the nurse in charge that the resident's daughter removed food from her mother's tray stating, "You are going to get too fat, Mom" and that this has been happening more. The entry further indicated the "daughter was seen inspecting her mother's genital area". 4. On 11/24/2011, 9 days following an 11/15/2011 readmission from the hospital, a nurse noted a 3-inch, deep purple bruise on the resident's right upper forearm... "Family notified - dtr (daughter) said that bruise happened in the hospital - no one noted this bruise prior to today - cont (continue) to	F 224	**With regard to Resident ID #7:** The facility disputes any suggestion that this alleged deficiency constituted immediate jeopardy as to resident ID #7, either at December 22, 2011 or at January 9, 2012. "This resident was not identified to the facility as incorporated within this IJ tag until January 9, 2012." a) Resident left the facility on 1/9/2012. As of that date, the area on the bunion, scraped by podiatrist had healed and staff was applying a protective dressing. b) Each resident in the facility was assessed for the need for podiatry services. This assessment was completed on 1/8/2012. c) A new procedure was implemented on 1/6/2012 to ensure that all residents are assessed for and offered podiatric services soon after admission and based on preference and need, to be placed on podiatry list for visits to manage an acute problem or routine nail care Beginning, 1/17/2012 any resident who refuses the offer to shower as scheduled is reported to the charge nurse. Charge nurse will determine the reasons for refusal and explore potential alternatives. Supervisory staff will review shower lists weekly to ensure that documentation is present and accurate. Nurses that documented that skin checks were completed without identifying problem during the months of November and December have been counseled regarding proper procedure. This task was complete by 1/20/2012.	1/8/12 1/6/12 1/17/12 1/20/12

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F 224	Continued From page 2 monitor". A review of the Witness Statement from the Smithfield Police Department relative to the allegation of abuse revealed that on 12/2/2011 a Nursing Assistant (NA) [employee I] told police of witnessing the resident's daughters with their heads underneath the resident's blanket in the area of her genitals. Additionally, the NA reported that in September 2011, she witnessed one daughter spread her mother's labia and insert her right index finger into the resident's vagina. On another occasion, the NA witnessed the other daughter "spread her mother's cheeks and rub her anus". On 11/24/2011, the NA witnessed a daughter inserting a finger into her mother's rectum. Although the facility uses briefs which show a blue line when the brief is wet, the NA saw both daughters put their hands down their mother's brief to see if she was wet on several occasions. The NA further told police that she reported all of these incidents to the nurses in charge (employees J, Q and R). Further review of Witness Statements revealed that 2 NA(s) [employees I and E] also witnessed the resident calling out "No" and "Stop it" when the daughters were with the resident. Although the facility was made aware of the above alleged incidents, the facility neglected to conduct any investigations and allowed the daughters to visit their mother twice daily without ever assessing or monitoring these visits in order to determine the validity of these allegations reported by staff.	F 224	Licensed nursing staff was reeducated about the expectations and procedures for completing skin checks weekly. This education occurred on 1/12/2012. All nurses not in attendance at this meeting are being reeducated by shift supervisors with this task completed by 1/20/2012. d) Weekly skin checks conducted by charge nurses will be monitored by supervisory staff with spot checks conducted randomly to ensure accuracy. These QI audits (spot checks) will be a part of our ongoing QI program; results will be shared with the QI committee.	1/20/12

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F 224	Continued From page 3 When interviewed separately by the surveyor on 12/20/2011 at 12:30 PM and 12:45 PM, the Director of Nurses (DNS) and Administrator respectively revealed that in addition to the previously reported allegations, the Alliance had contacted the DNS on 11/21/2011 regarding an anonymous complaint regarding the resident's daughter being observed with her head under the resident's blanket close to the resident's "bottom". Additionally, the complainant alleged that the daughters have been seen touching the resident in her genital area and then smelling their fingers. The DNS and Administrator revealed that they met with the daughters on 11/21/2011 and discussed the allegations in the complaint. They further stated they met with staff on 11/23/2011 after staff reported additional information of alleged inappropriate touching by the daughters and again on 11/30/2011 when a NA (employee I) reported observing the resident's daughters spreading the resident's labia and running their fingers down and into the resident's vagina on 11/23/2011. Although the NA did not report the 11/23/2011 incident timely, the DNS was unable to provide evidence the NA had been counseled or re-educated. Additionally, when the Administrator was interviewed on 12/21/2011 at 11:00 AM he revealed he had met with the daughters sometime in March 2011 to discuss staff reports that they were touching the resident's peri and buttock areas to check for wetness.	F 224		

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F 224	Continued From page 4 Although the Administrator advised the daughters to not continue with these behaviors, he was unable to provide any evidence of investigation of the above-alleged incidents and of protecting the resident by any monitoring and supervision of the daughters. When interviewed on 12/21/2011 at 12:45 PM, the social worker (SW) who attended the 11/23/2011 meeting confirmed that the staff was specific in reporting that the daughters were continuing to touch the resident's peri area and opening her labia to see if it was wet. Staff also reported observing the daughters putting their hand in the resident's brief and putting their heads under the sheets near the resident's peri area and buttocks. The SW could not provide evidence of any investigation of the alleged incidents. Additionally, she could not provide evidence of any system in place to protect the resident. When questioned on 12/21/2011 at 1:45 PM regarding the incident of the resident's daughter taking the pills from the nurse on 10/16/2011, the DNS revealed she became aware of the incident on 11/13/2011 when reviewing the resident's chart. When asked if she spoke to the nurse or the family, the DNS revealed she had only spoken to the nurse about timely reporting but had not spoken to the family because the incident had already happened. When asked what system the facility has put in place to protect the resident, the DNS revealed that the facility has yet to determine what steps needed to be taken as the investigation was not yet complete.	F 224		

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F 224	Continued From page 5 When interviewed on 12/21/2011 at 2:20 PM, a NA (employee K) who has provided care to the resident revealed that on 2 occasions she observed the resident's daughters putting their hand in the resident's brief between the brief and vagina or anus and then trying to put their hand up to the NA's face and asking if their hands smelled clean. Although the NA could not recall the specific dates, she revealed that these incidents happened as long ago as June or July 2011 and she reported both incidents to the nurse in charge. The surveyor conducted a telephone interview on 1/10/2011 at 3:50 PM with an RN (employee F) who is the 3-11 PM supervisor. The RN supervisor revealed that she was made aware of the above allegations over a period of time, perhaps as long ago as July 2010. The allegations were reported to her by virtually all the NA(s) and nurses who provided care for the resident, which included employees E, I, K and S who are NA(s) and employees J, Q and R who are nurses. Additionally, she witnessed one daughter checking the resident's peri area and the resident saying: "No, no, it hurts." The daughter replied: "I'm doing this for you". Although the RN supervisor could not recall the specific date, she revealed that she reported this incident to the DNS just as she had previously reported every allegation and concern brought to her attention by staff.	F 224		

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F 224	Continued From page 6 The RN supervisor continued to reveal that the DNS responded by saying that meetings were being held with the daughters and that the situation was being handled. In response to the RN supervisor asking about what limitation could be placed on the family, the DNS responded that the facility could not prohibit them from interfering with or providing care to their mother. Although the RN supervisor revealed that she and other staff were very frustrated by the lack of action by the DNS and Administrator, she revealed that she neglected to report any of the allegations to the Department of Health. Although the Administrator, DNS, SW and RN supervisor were aware of these allegations as early as March 2011 the facility failed to provide evidence of any protection provided to the resident prior to 11/30/2011 when, on the advice of the Alliance, the facility invoked a "No Trespass" order against the daughters and contacted the police. 2. Resident ID #7 was admitted to the facility on 2/18/2011 with a diagnosis of Dementia and Depression. A review of the resident's 11/2/2011 quarterly Minimum Data Set reveals a BIMS (Brief Interview for Mental Status) score of 5 out of 15 indicating severe cognitive impairment. The resident is occasionally incontinent and needs staff assistance for toileting, and is dependent on staff for bathing and personal hygiene. A review of the resident's "ADL Deficit Care Plan" reveals interventions to assist with bathing as the resident allows, encourage her to shower on her shower days and monitor her refusals as well as	F 224		

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F 224	Continued From page 7 monitor for changes in decline in personal care. A review of information attached to a complaint by the resident's family of alleged neglect revealed an allegation the resident had not received foot care since her admission on 2/18/2011. Additionally, the family alleged the resident had a strong odor like she had not been bathed in days. Review of the resident's Treatment Administration Records from 2/18/2011 through 11/5/2011 revealed that the resident had skin checks weekly with no areas of concern noted. The 11/12/2011 skin check identified long overgrown toenails. The subsequent weekly skin checks from 11/19 to 12/31/2011 continue to document no areas of concern, although the resident had seen a podiatrist on 12/29/2011 and returned with a surgical wound from debridement of ulceration over the bunion area of the right foot. Furthermore, review of the facility's Daily Shower Log for this resident revealed that the resident was to have showers twice weekly. The shower logs from February through July 2011 could not be produced by the facility. A review of the shower logs from August 2011 through 1/9/2012 revealed that 2 resident refusals to have a shower over a 4-month period was the only documentation. Additionally, the family arranged for and transported the resident to the podiatrist on 12/29/2011 due to their concerns about the condition of her foot. The surveyor reviewed the 12/29/2011 Podiatry	F 224		

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F 224	Continued From page 8 Office Note with the podiatrist on 1/6/2012 at 1:00 PM. The podiatrist revealed the resident was a long-term patient from 2007 to 2010. He further revealed that the resident appeared to not have her feet cared for in some time. The resident's diagnoses of Peripheral Vascular Disease (PVD) and a chronic bunion required podiatry visits for nail care every 3-4 months. The podiatrist's note continues to say, "Examination of her toes shows severely neglected feet with dystrophic elongated nails so long that they have begun and pinching on the surrounding skin and the skin of the neighboring toes... she has developed a grade 1 ulceration... at the bunion area on the right foot... Based on the appearance is likely been present for over a month probably longer..." Surveyor interview with the resident's daughter on 1/9/2012 at 10:15 AM revealed that, since the resident's admission, she expected the facility to be providing care for her mother's feet and toes. When the family saw the condition of their mother's feet and toes during a visit on 12/24/2011, they realized that the facility was not addressing foot care. She added that the family was surprised by the condition of the resident's feet because they brought their concerns about the condition of her feet to the facility approximately 8 weeks prior to 12/24 visit. Additionally, the daughter revealed that, for as long as she could remember, her mother did have a chronic bunion but never had any pressure blisters, or broken skin conditions on that area before.	F 224		

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F 224	Continued From page 9 When interviewed on 1/9/2012 at 2:00 PM the Director of Nurses (DNS) could not produce evidence the resident was bathed twice weekly or that routine foot care was provided.	F 224		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	**F225** Resident ID #1- daughters have not been in the facility since 12/1/2011. a) The Director of Nurses is no longer employed by this facility. The Administrator has been counseled by the EVP of Operations regarding his responsibility to investigate all complaints and allegations, to protect the residents during the conduct of investigations and to ensure timely follow-up reporting. Employees ID: E, I, J and S were counseled for failure to report in a timely manner. The last of the warnings were reviewed and signed on 12/29/2011. b) We have reviewed and did not identify any other residents affected by this issue. Each reportable event that has occurred since 12/29/2011, inclusive of bruising or any other injury of unknown origin has been effectively investigated and reported to appropriate agencies, in a timely manner. Each of these events were summarized in a report to the Department of Health and submitted within five (5) days of the initial report. The Administrator and Director of Nurses will ensure that the reporting procedures above will be followed for any new reportable event.	12/29/11

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F 225	Continued From page 10 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately (within 24 hours) to the State Survey and Certification Agency in accordance with State law for 1 of 12 sample residents, ID #1.. The facility also failed to fully investigate and prevent further potential abuse while the investigation is in progress for ID #1 and failed to report the result of all investigations within 5 working days of the incident for ID#(s) 1, 2 and 3. Findings are as follows: 1. Resident ID #1 was admitted to the facility on 1/31/2011 with a diagnosis of Dementia. A review of the 10/13/2011 quarterly Minimum Data Set reveals a BIMS (Brief Interview for Mental Status) score of 4 out of 15 indicating severe cognitive impairment. The resident is incontinent and is dependent on staff for personal hygiene. A review of nurses' notes revealed the following: 1. On 8/10 and 9/13/2011 the resident's daughter(s) inspected her peri (genital) area.	F 225	c) A new procedure was implemented on December 2, 2011 by which the Administrator and/or Director of Nursing must report to corporate staff; the Director of Clinical Services and/or the VP of Operations that an allegation has been received, the steps taken toward investigation and resolution and the manner in which the resident is protected during the investigation. On-going monitoring will be done by the Director of Clinical Services. All supporting documentation will be reviewed for content, completeness and compliance with reporting guidelines. The Administrator and Director of Nurses will ensure that the reporting procedures above will be followed for any new reportable event. d) A Supervisor-to-Administrator report has been developed and implemented. Each shift supervisor speaks with all staff on duty while collecting report to determine if any reportable event occurred during the shift. Administrative staff reviews the report to determine if a concern requiring report and/or investigation occurred. The Administrator is ultimately responsible to ensure ongoing compliance of this issue. **With regard to resident ID #2:** a) "This resident was not identified to the facility as incorporated within this IJ tag until January 9, 2012." Resident ID#2 is stable. The facility disputes any suggestion that this alleged deficiency constituted immediate jeopardy, either at December 22, 2011 or at January 9, 2012. The facility received no deficiency as to this resident at December 22, 2011. In fact, as noted below, the employee in question had been suspended on the date the facility became aware of the allegation.	12/2/11

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F 225	Continued From page 11 2. On 10/16/2011 the resident choked and spit out her medications when her daughter took the medication cup from the nurse and put the medications into the resident's mouth. 3. On 11/20/2011 a nursing assistant informed the nurse in charge that the resident's daughter removed food from her mother's tray stating, "You are going to get too fat, Mom" and that this has been happening more. The entry further indicated the "daughter was seen inspecting her mother's genital area". 4. On 11/24/2011, 9 days following a readmission on 11/15/2011 from the hospital, the nurse noted a 3-inch, deep purple bruise on the resident's right upper forearm... "Family notified - dtr (daughter) said that bruise happened in the hospital - no one noted this bruise prior to today - cont (continue) to monitor". There lacked any evidence the facility conducted any investigations, reported the above incidents or implemented and monitored the daughters' physical contact with the resident. When interviewed separately on 12/20/2011 at 12:30 PM and 12:45 PM, the Director of Nurses (DNS) and Administrator respectively revealed that a representative from the Alliance for Better Long-term care (Alliance) had contacted the DNS on 11/21/2011 about receiving an anonymous complaint regarding the resident's daughter being observed with her head under the resident's blanket close to the resident's "bottom". Additionally, the complainant alleged that the daughters have been seen touching the resident in her genital area and then smelling their fingers.	F 225	Employee ID: T. was suspended from work on 11/19/2011 during conduct of the investigation and is no longer employed by this facility. **With regard to Resident ID #3:** This resident was not identified to the facility as incorporated within this IJ tag until January 9, 2012." The facility disputes any suggestion that this alleged deficiency constituted immediate jeopardy as to this resident either at December 22, 2011 or at January 9, 2012. There was no harm associated with the report going to the Department 9 days after the alleged incident rather than 5 days after the alleged incident. The nursing assistant ID: A that failed to report the allegation of inappropriate conduct was counseled on 12/6/2011 as to the importance of timely reporting. Nursing assistant ID: U was suspended upon facility learning of the allegation of inappropriate actions. An investigation was conducted and the nursing assistant given permission to return to work on a different unit. b) We understand that other residents could be potentially affected by the issues noted by the survey team; however, at this time we have not identified any further issues of concern.	11/19/11 12/6/11

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F 225	Continued From page 12 The DNS and Administrator further revealed that they met with the daughters on 11/21/2011 and discussed the allegations in the complaint to the Alliance. Additionally, they met with staff on 11/23/2011 when staff reported additional inappropriate behaviors by the daughters and again on 11/30/2011 when a NA (employee I) reported observing reported observing the resident's daughters spreading the resident's labia and running their fingers down and into the resident's vagina on 11/23/2011. Although the NA did not report the 11/23/2011 incident timely, the DNS was unable to provide evidence the NA had been counseled or re-educated regarding timely reporting of abuse, neglect and mistreatment. Additionally, the Administrator revealed he had met with the daughters sometime in March 2011 to discuss staff reports that they were touching the resident's peri and buttock areas to check for wetness. Although the Administrator advised the daughters to not continue, he was unable to provide any evidence of reporting to the state agency or of monitoring the daughters' compliance. When interviewed on 12/21/2011 at 2:20 PM, a NA (employee K) revealed that on 2 occasions she observed the resident's daughters putting their hand in the resident's brief between the brief and vagina or anus and then trying to put their hand up to the NA's face and asking if their hands smelled clean. The NA further revealed that these incidents	F 225	c) A new procedure ✓ was implemented on December 2, 2011 by which the Administrator and/or Director of Nursing must report to corporate staff; the Director of Clinical Services and/or the EVP/CEO that an allegation has been received, the steps taken toward investigation and resolution and the manner in which the resident is protected during the investigation. On-going monitoring will be done by the Director of Clinical Services. All supporting documentation will be reviewed for content, completeness and compliance with reporting guidelines. The Administrator and Director of Nurses will ensure that the reporting procedures above will be followed for any new reportable event.	12/2/11

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happened as long ago as June or July 2011 and she reported both incidents to the nurse in charge.

Although the Administrator and DNS were aware of these allegations as early as March 2011 they failed to provide evidence of any reporting, investigating or implementation of a plan to protect the resident until 11/30/2011 when, on the advice of a representative of the Alliance for Better Long Term Care, they faxed a "Documentation of Required Reporting" (R23-17-NF-Appendix E) to the Department of Health, Division of Facilities Regulation, (DOH), invoked a "No Trespass" order on the daughters and called the police.

The above reporting was not immediate but rather 10 days after 11/21/2011 when the Alliance contacted the facility about the allegations. A summary report was faxed to the DOH on 12/8/2011 which was not within 5 working days of the allegations but rather 8 days after 11/30/2011 and 18 days 11/21/2011.

2. An incident of verbal abuse by a NA (employee T) toward resident ID #2 was reported to the DOH on 11/19/2011. A Facility Incident Summary Report was faxed to the DOH on 11/25/2011, which was 7 days after 11/19/2011 rather than 5 days as required.

When interviewed on 12/22/2011 at 9:45 AM the DNS was unable to provide evidence that the results of the investigation were reported to the DOH within 5 days of the allegation.

3. An incident of inappropriate behavior by a NA

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F 225	Continued From page 14 (employee U) toward resident ID #3 was reported to the DOH on 11/23/2011. A Facility Incident Summary Report was faxed to the DOH on 12/1/2011, which was 9 days after 11/23/2011 rather than the 5 days as required. When interviewed on 12/21/2011, at 9:45 AM, the DNS was unable to provide an explanation for the late reporting.	F 225		
F 226 SS=K	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents for 3 of 5 sample residents (ID #s 1, 2 and 3). Findings are as follows: The facility's policy and procedure titled "Abuse Prohibition" states: "II. Procedure: To protect the resident from abuse, mistreatment, neglect and/or misappropriation of their personal property and to further the goal of providing respectful treatment..." D. Identification and Reporting... Any instance of actual or suspected abuse, neglect... including injuries of unknown origins including bruises, skin	F 226	**F 226** The facility disputes any suggestion that this alleged deficiency constituted immediate jeopardy as to residents ID #2 and 3, either at December 22, 2011 or at January 9, 2012. a) Residents ID# 1, 2, and 3 are stable and without any untoward effect. b) We recognize that other resident could be affected by the issues noted by the survey team however; we have not identified any further issues at this time. c) The facility policy that addresses abuse referred to in the 2567 has been reviewed and revised to reflect actual practices and procedures, which are in compliance with state and federal regulations. Although the daily practices were modified immediately, modifications to the written policy were complete by 1/20/2012. All staff has been reeducated about definitions of abuse, neglect and mistreatment, timeliness of reporting and protecting the resident during the conduct of an investigation. This education was completed 12/27/2011.	12/27/11 1/20/12

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F 226	Continued From page 15 tears... must be reported immediately to the supervisor on duty and an incident report is to be filled out. E. Investigation... It is the supervisor's responsibility to act immediately to: Begin the initial investigation... Intervene to ensure that the resident is safe and protected from further harm... Obtain statements from witnesses... Notify the appropriate administrative personnel so that a comprehensive internal facility investigation can be carried out... Carry out proper staff interventions and include all interventions in the resident's care plan... It is the responsibility of the Director of Nursing to ensure that: The incident reports are accurately and completely filled out; personnel and witness statements are obtained timely; the investigation is comprehensive and documented appropriately... It is the responsibility of the Nursing Home Administrator to... Notify the appropriate agencies in writing... Submit the report of allegations and the results of the internal investigation to the Department of Health. F. Timelines of investigation All allegations of violations in this policy must be reported immediately to the Department of Health Division of Facility Regulation. The facility must then begin the internal investigation, which is to be completed and forwarded to the Department of Health within 5 days." 1. A review of nurses' notes from 8/10 to	F 226	Nursing assistant ID: D who failed to report to the charge nurse on the evening shift, that she overheard the comment, was counseled on 12/19/2011 verbally and 12/23/2011 in writing, in accordance with facility policy. d) The Administrator is responsible to ensure polices are being followed and will review any allegation reported; appropriate reporting policies will be followed.	12/19/11

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F 226	Continued From page 16 11/14/2011 in the clinical record for resident ID #1 revealed 3 instances of the resident's daughter(s) being observed touching and inspecting her peri (genital) and anal areas, an instance of the resident's daughter giving her mother medication resulting in the resident choking and spitting out the medication, an instance of the resident's daughter removing food from the resident's tray and referring to her getting too fat, and the discovery of a bruise on the resident's arm which could not be explained. There lacked evidence the facility completed incident reports, conducted investigations and/or reported, developed, monitored and reassessed intervention strategies and included the interventions in the resident's care plan. Additionally, there was no evidence the facility notified the appropriate agencies or submitted the report of allegations and the results of the internal investigation to the Department of Health in accordance with the facility's policy and procedure. On 11/21/2011, an allegation of abuse toward the resident by her daughters was reported to the facility. When questioned on 12/22/2011 at 10:00 AM, the DNS and Administrator were unable to provide evidence of any investigation and reporting prior to 11/30/2011 when, on the advice of a representative for the Alliance for Better Long Term Care, the facility faxed a "Documentation of Required Reporting" (R23-17-NF-Appendix E) to the Department of Health, Division of Facilities Regulation, (DOH). The above reporting was not immediate but rather 10 days after 11/21/2011 when the Alliance	F 226		

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F 226	Continued From page 17 contacted the facility about the allegations. A summary report was faxed to the DOH on 12/8/2011 which was not within 5 working days of the allegations but rather 8 days after 11/30/2011 and 18 days 11/21/2011. The above timelines are not in accordance with the facility's policy and procedure. The DNS and Administrator were also unable to provide evidence they had developed, monitored and reassessed intervention strategies and included the interventions in the resident's care plan as specified in the facility's policy and procedure. 2. An incident of verbal abuse by a NA (employee T) toward resident ID #2 was reported to the DOH on 11/19/2011. A Facility Incident Summary Report was faxed to the DOH on 11/25/2011, which was 7 days after 11/19/2011 rather than the 5 days specified in the facility's policy and procedure. A review of the 11/22/2011 staff's written statement and the 11/22/2011 Facility Witness Statement/Interview Documentation Form revealed the incident occurred on 11/18/2011, however, the witness (employee D) did not report the incident immediately to the nursing supervisor on duty but rather 1 day later on 11/19/2011. When questioned on 12/22/2011 at 9:45 AM, the DNS indicated that the alleged perpetrator continued to work after the incident on 11/18 and was not suspended until 11/19 when the DNS began the investigation. The DNS was unable to provide evidence that the	F 226		

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F 226	Continued From page 18 witness reported the above allegation of verbal abuse immediately to the supervisor on duty and the resident was protected by the immediate removal of the alleged perpetrator or that the results of the investigation were reported to the DOH within 5 days of the incident in accordance with the facility's policy and procedure. 3. An incident of inappropriate behavior by a NA toward resident ID #3 (employee U) was reported to the DOH on 11/23/2011. A Facility Incident Summary Report was faxed to the DOH on 12/1/2011, which was 9 days after 11/23/2011 rather than the 5 days required by the facility's policy and procedure. When interviewed on 12/21/2011, at 9:45 AM, the DNS was unable to provide evidence the facility followed it's policy and procedures that prohibit mistreatment, neglect, and abuse.	F 226		
F 241 SS=K	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity for 1 of 12 sample residents, ID #1. Findings are as follows:	F 241	**F 241** **a) Regarding Resident ID #1:** Resident's daughters have not been in the facility since 12/1/2011. b) We have not identified any other resident affected by the issues noted by the survey team and we will certainly continue to monitor this. c) Administrator and Director of Nursing were reeducated on 12/1/2011 about resident's rights with regard to family interference with care by the Director of Clinical Services. On 1/12/2012, licensed nursing personnel were reeducated about resident's rights with regard to family interference with care. All were informed that although we partner with our families during the development of care plan and in decision making whenever needed, the facility has the right to set limits with any family found to be impeding a resident's dignity and how that can be accomplished. All nurses not in attendance at this meeting are being reeducated by shift	

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F 241	Continued From page 19 Resident ID #1 was re-admitted to the facility 1/31/2011. She has lived in the facility since 8/31/2007 and has a diagnosis of Dementia. A review of the 10/13/2011 quarterly Minimum Data Set reveals a BIMS (Brief Interview for Mental Status) score of 4 out of 15 indicating severe cognitive impairment. The resident is incontinent and is dependent on staff for personal hygiene. A review of information attached to a complaint of alleged abuse by family revealed numerous accounts by staff (nursing assistants and nurses) reporting concerns regarding what they considered to be inappropriate touching and inspection of the resident's private areas by both of her daughters. This information included "Journal Entries" written by a representative from the Alliance for Better Long Term Care (Alliance) and an Incident Report and Witness Statements from the local police department. A review of nurses' notes revealed that on 8/10, 9/13 and 11/20/2011 the resident's daughter(s) were seen touching/inspecting her peri (genital) areas. Additionally, the 11/20 note reveals the resident's daughter removes food from her tray and referring to her getting too fat and that this is happening more often. When interviewed separately on 12/20/2011 at 12:30 PM and 12:45 PM, the Director of Nurses (DNS) and Administrator revealed respectively that a representative of the Alliance for Better Long-term care (Alliance) had contacted the DNS on 11/21/2011 about an anonymous complaint regarding the resident's daughter being observed with her head under the resident's blanket close	F 241	supervisors with this task completed by 1/20/2012. d) The Administrator is ultimately responsible to ensure ongoing compliance. The Administrator will review any allegations to ensure proper procedures are being followed.	1/20/12

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to the resident's "bottom". Additionally, the complainant alleged that the daughters have been seen touching the resident in her genital area and then smelling their fingers.

The DNS and Administrator further revealed that they met with the daughters on 11/21/2011 and discussed the allegations in the complaint. Additionally, they met with staff on 11/23/2011 when staff reported additional inappropriate touching and inspection by the daughters and again on 11/30/2011 when a NA (employee I) reported observing the resident's daughter spreading the resident's labia and running her fingers down and into the resident's vagina on 11/23/2011.

Additionally, when the Administrator was interviewed on 12/21/2011 at 11:00 AM, he revealed he had met with the daughters sometime in March 2011 to discuss staff reports that they were touching the resident's peri and buttock areas to check for wetness. Although the Administrator advised the daughters to not continue with this behavior, he was unable to provide any evidence of monitoring their compliance.

When interviewed on 12/21/2011 at 12:45 PM, the social worker (SW) who attended the 11/23/2011 meeting revealed that the staff was specific in reporting that the daughters were continuing to touch the resident's peri area and opening her labia to see if it was wet. Staff also reported observing the daughters putting their hand in the resident's brief and putting their heads under the sheets near the resident's peri area and buttocks.

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F 241	Continued From page 21 When interviewed on 12/21/2011 at 2:20 PM, a NA (employee K) who has provided care to the resident revealed that on 2 occasions she observed the resident's daughters putting their hand in the resident's brief between the brief and vagina or anus and then trying to put their hand up to the NA's face and asking if their hands smelled clean. The NA further revealed that these incidents happened as long ago as June or July 2011 and she reported both incidents to the nurse in charge. There lacked any evidence the facility addressed the issue of dignity with the resident's daughters or staff or that the resident's dignity was ensured by evidence of a care plan to prevent further occurrences. Although the Administrator and DNS were aware of the daughters' inappropriate behavior as early as March 2011 they were unable to provide evidence the facility promoted care in a manner and in an environment that maintains or enhances each resident's dignity.	F 241		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based record review, family and staff interviews,	F 247	**F 247** ***We are respectfully disputing this deficiency.*** a) Resident ID #7 was admitted on 2/18/2011. The resident was having difficulty sleeping due to the roommate. Resident was offered the opportunity to move to another room. Resident accepted the room change and was capable of making this decision. The move was made for the benefit of the resident. This resident is no longer at our facility.	

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F 247	Continued From page 22 it was determined that the facility failed to provide prior notice of a room change for 1 sample resident, ID #7. Findings are as follows: Review of the clinical record of resident ID #7 revealed she was admitted to the facility on 2/18/2011 to South Unit room 6A. On 2/19/2011 she was transferred to North A Unit room 46A. Further record review revealed that the resident's responsible party was her daughter. A review of a 2/19/2011 nurse's note written at 6:00 AM revealed that the resident had difficulty sleeping and a room change may be required. An interview with the resident's daughter on 1/9/2012, at 10:15 AM revealed that when the family came into visit the resident on the next day, 2/19/2011, they were surprised that the resident was no longer in room 6A as they had not been notified of the room transfer. When interviewed on 1/9/2012 at 2:00 PM, the Director of Nurses revealed that although the resident was transferred on the morning of 2/19/2011, she was unable to provide evidence that the responsible party had been notified prior to the room change.	F 247	b) There were no other residents affected and we will continue to monitor this situation in order to ensure compliance. c) All room changes in the facility are done with consideration for the residents. There is discussion with the resident in advance of all moves with the exceptions of emergencies for resident safety. Responsible parties are contacted when the resident is incompetent to make a decision and/or after a resident has made a decision to make a move. Responsible parties will be notified according to state and federal regulations. d) Nursing management and/or Social Service staff will be responsible to ensure ongoing compliance. Our findings will be shared with the QI committee.	1/20/12
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	**F 250** a) Resident ID#1 is stable and this resident's needs are being addressed accordingly. b) We have not identified any further issues with other residents who may be affected by those issues identified by the survey team.	REVIEW ND 1/26/12

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F 250	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident relative to an allegation of abuse by family for resident ID #1. Findings are as follows: Resident ID #1 was re-admitted to the facility on 1/31/2011. She has lived in the facility since 8/31/2007 and has a diagnosis of Dementia. A review of the 10/13/2011 quarterly Minimum Data Set reveals a BIMS (Brief Interview for Mental Status) score of 4 out of 15 indicating severe cognitive impairment. The resident is incontinent and is dependent on staff for personal hygiene. A review of information attached to a complaint of alleged abuse by family revealed numerous accounts by staff (nursing assistants and nurses) reporting concerns regarding what they considered to be inappropriate touching and inspection of the resident's private areas by both of her daughters. This information included "Journal Entries" written by a representative from the Alliance for Better Long Term Care (Alliance), an Incident Report and Witness Statements from the local police department and written statements by witnesses. All above staff reported they had reported these many incidents to their supervisors, including the Director of Nurses and the Administrator as early	F 250	c) The social worker was included in the reeducation of the staff with regard to abuse identification, reporting and timeliness. The social worker was also reeducated about her role in providing protection to a resident during the conduct of an investigation. Additionally, the social worker has been informed of the new procedures that require that the Administrator and/or Director of Nurses to report all allegations to the corporate support staff as well as the on-going monitoring of outcome and documentation through to resolution. d) Compliance with these practices will be monitored by the Director of Clinical Services and findings shared with the QI committee when appropriate.	1/30/12

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F 250	Continued From page 24 as March 2011. A review of quarterly social service notes dated 5/18, 8/5 and 11/2/2011 failed to reveal any documentation of social services provided to the resident relative to the above allegations. When interviewed on 12/21/2011 at 12:45 PM, the social worker (SW) revealed being aware of staff concerns of the daughters inappropriate touching the resident before the Alliance contacted the facility on 11/21/2011 regarding an allegation of abuse by the daughters toward the resident. When asked whether she had met with the family to discuss these concerns before 11/21/2011, the SW indicated that the DNS and Administrator had spoken with the daughters, however, the daughters were difficult to deal with as they were overly involved in the resident's care and were not easily directed. The SW could not provide evidence of any investigation of the alleged incidents. Additionally, she could not provide evidence of any system in place to protect the resident. Refer to F224, F 225, F226 and F241	F 250		
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**F 323** The facility is disputing this deficiency as to the duplicative language that begins at the bottom of page 28 of 39 and continues through page 31 of 39. This language appeared on page 26 of 39 and continues through page 28 of 39 and should be deleted. a) Resident ID #4 no longer resides at this facility. b) We have since reviewed residents with a high risk to fall and have assured care plan interventions are appropriate and being implemented.	

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F 323	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with a representative for the Alliance for Better Long Term Care (Alliance) and the DNS (Director of Nurses), it was determined the facility failed to ensure that each resident receives assistance devices to prevent accidents for 1 of 12 sample residents (ID #4). Findings are as follows: Surveyor review of 10/31/2011 complaint revealed an allegation by family that resident ID #4 had three falls and sustained injuries requiring emergency room (ER) visits within her four month stay at the facility. The complainant alleged that the resident's safety measures (grippers socks, call light and bed/chair alarms) were not in place according to the plan of care. The complainant indicated that on the advice of the Alliance the resident was moved to another facility on 9/23/2011 because of concerns for her safety. Record review revealed the resident was admitted to the facility with diagnoses of Stomach Cancer, Hypertension, Congestive Heart Failure, Atrial Fibrillation, Anxiety, Anemia and Blindness in her left eye. A review of the 5/31 and 8/23/2011 Minimum Data Sets indicated the resident had cognitive impairment and she needed assistance with her ADL(s) {Activities of Daily Living} including bed mobility, transferring and ambulation. Fall Risk Assessments dated 5/23, 5/28, 8/2 and 9/6/2011 indicated the resident was	F 323	c) Each resident that is assessed as a fall risk either due to physical limitation or the inability to understand or recall their limitations has a care plan to identify the risk. If a fall occurs, the staff investigates to determine the cause of the fall. An intervention is implemented to prevent further falls and is written on the care plan. Nursing assistant care cards will include information regarding interventions added to the care plan to promote safety to ensure that they are in place and functioning properly. Charge nurses will monitor placement and function, reporting any malfunctions as identified. d) The nursing management team will conduct QI audits to ensure fall interventions are appropriate and in place per care plan. These audit findings will be shared with the QI committee.	1/20/12

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F 323	Continued From page 26 at high risk for falls. A 6/3/2011 Interdisciplinary Care Plan indicated the resident needed assistance with her ADL(s) due to poor balance, poor safety awareness, forgetfulness and needing assistance with bed mobility and transfers and was incontinent of urine at times. The care plan also indicated the resident was at risk for falls due to anti-depressant and anti-anxiety use and a history of multiple falls at her prior living facility. In addition the resident was to have a call light within reach and staff would provide assistance with her ADL(s) as needed. Further record review revealed that on 6/7/2011, the resident was found sitting on the floor with a small abrasion to her right shoulder and a small laceration to her right scalp. The resident was transported to the emergency room (ER). The family met with the DNS and was assured that the safety measures in the care plan would be in place. Gripper socks were added to the care plan. A 6/21/2011 nurse's note indicated the resident frequently did not have her call light within reach while she was in the bed or chair. Although, the resident had periods of forgetfulness, the note further indicated that the resident was encouraged to remind staff to attach the call light and put on the gripper socks. On 8/2/2011, the resident was found on the floor on the side of her bed during rounds at 7:00 AM. The resident was noted with a bump and small cut over her right eye and a skin tear on her right elbow. The resident was sent to the ER due to hitting her head.	F 323		

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F 323	Continued From page 27 An 8/2/2011 nurse's note, written at 8:00 AM indicated the resident's personal alarm was in place but didn't sound due to needing replacement batteries. The nurse's note also indicated the resident now complained of pain in her neck and a headache and she was discouraged that she had fallen again. The family again met with the DNS and was told that more safety protocols would be put into place. Record review revealed both bed and chair alarms were added to the resident's plan of care to increase resident safety after the fall incident on 8/2/2011. During a phone interview on 12/22/2011 at 10:15 AM, the Alliance revealed visiting the resident on 9/21/2011. The resident was lying in bed without gripper socks on, without a call light within reach and although the alarm was on, it was not working. The Alliance immediately informed the DNS. When questioned on 12/22/2011 at 10:30 AM the DNS revealed she was aware the gripper socks, alarms and call bell were not consistently working and/or provided to the resident as assistance devices to ensure the resident's safety. She was unable to produce evidence the facility had implemented and/or monitored staff compliance with these interventions to prevent accidents. Based on record review and interviews with a representative for the Alliance for Better Long Term Care (Alliance) and the DNS (Director of	F 323		

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Nursing Services), it was determined the facility failed to ensure that each resident receives assistance devices to prevent accidents for 1 of 12 sample residents (ID #4).

Findings are as follows:

According to the 10/31/2011 Complaint Form, the family alleged that resident ID #4 had three falls with emergency room visits resulting in injury from the falls within her four month stay at the facility. The complainant alleged that the resident's safety measures (grippers socks, call light and bed/chair alarms) were not in place according to the plan of care. The complainant indicated that on the advice of the Alliance the resident was moved to another facility on 9/23/2011 because of concerns for her safety.

Record review revealed the resident was admitted to the facility with diagnoses of Stomach Cancer, Hypertension, Congestive Heart Failure, Atrial Fibrillation, Anxiety, Anemia and Blindness in her left eye. A review of the 5/31 and 8/23/2011 Minimum Data Sets indicated the resident had cognitive impairment and she needed assistance with her ADL(s) {Activities of Daily Living} including bed mobility, transferring and ambulation. Fall Risk Assessments dated 5/23, 5/28, 8/2 and 9/6/2011 indicated the resident was at high risk for falls.

A 6/3/2011 Interdisciplinary Care Plan indicated the resident needed assistance with her ADL(s) due to poor balance, poor safety awareness, forgetfulness and needing assistance with bed mobility and transfers and was incontinent of urine at times. The care plan also indicated the

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resident was at risk for falls due to anti-depressant and anti-anxiety use and a history of multiple falls at her prior living facility. In addition the resident was to have a call light within reach and staff would provide assistance with her ADL(s) as needed.

Further record review revealed that on 6/7/2011, the resident was found sitting on the floor with a small abrasion to her right shoulder and a small laceration to her right scalp. The resident was transported to the emergency room (ER). The family met with the DNS and was assured that the safety measures in the care plan would be in place. Gripper socks were added to the care plan.

A 6/21/2011 nurse's note indicated the resident frequently did not have her call light within reach while she was in the bed or chair. Although, the resident had periods of forgetfulness, the note further indicated that the resident was encouraged to remind staff to attach the call light and put on the gripper socks.

On 8/2/2011, the resident was found on the floor on the side of her bed during rounds at 7:00 AM. The resident was noted with a bump and small cut over her right eye and a skin tear on her right elbow. The resident was sent to the ER due to hitting her head.

An 8/2/2011 nurse's note, written at 8:00 AM indicated the resident's personal alarm was in place but didn't sound due to needing replacement batteries. The nurse's note also indicated the resident complained of pain in her neck and a headache and she was discouraged that she fell again.

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F 323	Continued From page 30 The family again met with the DNS and was told that more safety protocols would be put into place. Record review revealed both bed and chair alarms were added to the resident's plan of care to increase resident safety after the fall incident on 8/2/2011. During a phone interview on 12/22/2011 at 10:15 AM, the Alliance revealed visiting the resident on 9/21/2011. The resident was lying in bed without gripper socks on, without a call light within reach and although the alarm was on, it was not working. The Alliance immediately informed the DNS. When questioned on 12/22/2011 at 10:30 AM the DNS revealed she was aware the gripper socks, alarms and call bell were not consistently working and/or provided to the resident as assistance devices to ensure the resident's safety. She was unable to produce evidence the facility had implemented and/or monitored staff compliance with these interventions to prevent accidents.	F 323		
F 328 SS=H	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	**F 328** a) Resident ID #7 no longer resides at this facility. Resident left the facility on 1/9/2012. As of that date, the area on the bunion, scraped by podiatrist had healed and staff was applying a protective dressing.	

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F 328	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, it was determined the facility failed to provide foot care for 1 of 6 sample residents whose feet were observed, ID #7. Findings are as follows: Resident ID #7 was admitted to the facility on 2/18/2011 with a diagnosis of Dementia and Depression. A review of the resident's 11/2/2011 quarterly Minimum Data Set reveals a BIMS (Brief Interview for Mental Status) score of 5 out of 15 indicating severe cognitive impairment. The resident is occasionally incontinent and needs staff assistance for toileting, and is dependent on staff for bathing and personal hygiene. A review of the resident's "ADL Deficit Care Plan" reveals interventions to monitor for changes in decline in personal care. A review of information attached to a complaint by the resident's family of alleged neglect revealed an allegation the resident had not received foot care since her admission on 2/18/2011. Review of the resident's Treatment Administration Records (TAR) from 2/18/2011 through 11/5/2011 revealed that the resident had skin checks weekly, which indicated there were no areas of concern noted. The 11/12/2011 skin check identified long overgrown toenails. The subsequent weekly skin checks from 11/19 to	F 328	b) Each resident in the facility was assessed for the need for podiatry services. This assessment was completed on 1/8/2012. c) A new procedure was implemented on 1/6/2012 to ensure that all residents are assessed for and offered podiatric services soon after admission and based on preference and need, to be placed on podiatry list for visits to manage an acute problem or routine nail care. Nurses that documented that skin checks were completed without identifying problems during the months of November and December have been counseled regarding proper procedure. This task was completed by 1/20/12. Licensed nursing staff was reeducated about the expectations and procedures for completing skin checks weekly. This education occurred on 1/12/2012. All nurses not in attendance at this meeting are being reeducated by shift supervisors with this task completed by 1/20/2012. d) Nursing management will complete random but routine audits regarding compliance with these skin checks so as to ensure optimal and proper documentation. These audit findings will be shared with the QI committee.	1/20/12

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F 328	Continued From page 32 12/24/2011 continue to document no areas of concern. Additionally, the family arranged for and transported the resident to the podiatrist on 12/29/2011 due to their concerns about the condition of her foot. The surveyor reviewed the 12/29/2011 Podiatry Office Note with the podiatrist on 1/6/2012 at 1:00 PM. The podiatrist revealed the resident was a long-term patient from 2007 to 2010. He further revealed that the resident appeared to not have her feet cared for in some time. The resident's diagnoses of Peripheral Vascular Disease (PVD), Onychomycosis (a fungal infection which causes toenails to thicken, discolor and disfigure as well as a chronic bunion required podiatry visits for nail care every 3-4 months. The podiatrist's note continues to say, "Examination of her toes shows severely neglected feet with dystrophic elongated nails so long that they have begun and pinching on the surrounding skin and the skin of the neighboring toes... she has developed a grade 1 ulceration... at the bunion area on the right foot... There is a large dorsal eschar... which appears to be secondary to an older blood blister. Based on the appearance is likely been present for over a month probably longer..." The podiatrist further revealed to the surveyor that the area he removed the dark and necrotic looking area from the bunion with a surgical blade. Surveyor interview with the resident's daughter on	F 328		

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F 328	Continued From page 33 1/9/2012 at 10:15 AM revealed that, since the resident's admission, she expected the facility to be providing care for her mother's feet and toes. When the family saw the condition of their mother's feet and toes during a visit on 12/24/2011, they realized that the facility was not addressing foot care. She added that the family was surprised by the condition of the resident's feet because they brought their concerns about the condition of her feet to the facility approximately 8 weeks prior. Additionally, the daughter revealed the resident's toenails were properly maintained prior to admission to the facility. She added that for as long as she could remember, her mother did have a chronic bunion but never had any pressure blisters, or broken skin conditions on that area before. When interviewed on 1/9/2012 at 2:00 PM the Director of Nurses (DNS) could not produce evidence the resident was bathed twice weekly or that routine foot care was provided.	F 328		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility was not administered	F 490	**F490** a) We have previously referred to our improvement plan throughout this Plan of Correction regarding those residents identified (ID#1, 2, 3, and 7). As noted in the plan of correction for tag # 225 and 226, the facility disputes any suggestion that this alleged deficiency constituted immediate jeopardy as to residents ID# 2 and 3 either at December 22, 1011 or at January 9, 2012. b) There were no additional residents identified during our improvement review and improvement processes however, we do recognize the importance of the matter.	

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F 490	Continued From page 34 in a manner that enabled it to use its resources effectively and maintain the highest practicable physical, mental and psychosocial well being of each resident. Findings are as follows: 1. As evidenced by the facility's failure to ensure that residents are free from neglect as referenced in F224 with S/S at the K level and resulting in the potential for serious harm. 2. As evidence by the facility failure to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately (within 24 hours) to the State Survey and Certification Agency. The facility failed to fully investigate and prevent further potential abuse while the investigation is in progress and failed to report the result of all investigations within 5 working days of the incident as referenced in F225 with S/S at the K level and resulting in the potential for serious harm. 3. As evidence by the facility failed to implement its own written policies and procedures that prohibit mistreatment, neglect, and abuse of residents as referenced in F226 with S/S at the K level and resulting in the potential for serious harm. 4. As evidence by the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity as referenced in F241 with S/S at the K level and resulting in the potential for serious harm.	F 490	c) All staff was reeducated as to the definitions of abuse, neglect and mistreatment as well as regarding reporting time frames and procedures. This task was completed in full on 12/27/2011.. The Director of Nurses is no longer employed by this facility. The Administrator has been counseled by the EVP of Operations regarding his responsibility to investigate all complaints and allegations, to protect the residents during the conduct of investigations and to ensure timely follow-up reporting. A new procedure was implemented on December 2, 2011 by which the Administrator and/or Director of Nursing must report to corporate staff; the Director of Clinical Services and/or the EVP of Operations that an allegation has been received, the steps taken toward investigation and resolution and the manner in which the resident is protected during the investigation. d) On-going monitoring will be done by the Director of Clinical Services. All supporting documentation will be reviewed for content, completeness and compliance with reporting guidelines.	12/27/11

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F 490	Continued From page 35	F 490		
F 501 SS=K	Refer to F224, F225, F226 and F241 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, it was determined the medical director failed to assist the facility to identify, evaluate and address medical and clinical concerns and issues that affect resident care, medical care, quality care and coordinate medical care in the facility. Findings are as follows: 1. As evidenced by the facility's failure to ensure that residents are free from neglect as referenced in F224 with S/S at the K level and resulting in the potential for serious harm. 2. As evidence by the facility failure to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source are reported immediately (within 24 hours) to the State Survey and Certification Agency. The facility failed to fully investigate and prevent further potential abuse while the investigation is in progress and failed to report the result of all investigations within 5 working days of the	F 501	**F 501** a) Although no residents were specifically mentioned in this particular tag, the references to 224, 225, 226 and 241 imply reference to residents 1, 2, 3 and 7. To that end our responses to those alleged deficiencies are incorporated herein including our disputing any suggestion that this alleged deficiency constituted immediate jeopardy as to residents 2, 3 and 7, either at December 22, 2011 or at January 9, 2012. b) Although no residents were mentioned in this tag, we do recognize the importance of the matter and are responding timely and appropriately. c) The Medical Director was provided an overview of the issues identified on 12/1/2011, by the Director of Clinical Services. Since that time, the Medical Director has been updated on all actions taken with regard to personnel changes, education, corrective actions and policy development. The Medical Director was informed of content of the 2567 report at the QI meeting held on 1/18/2012 and a copy of the 2567 report was forwarded for his complete review. d) The Administrator will ensure that the Medical Director coordinates medical care as appropriate, assists the facility to identify, evaluate, and address medical and clinical concerns and issues that affect resident care, and is involved with facility policies, QI/QA and meets other regulatory responsibilities.	1/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415049	A. BUILDING _____ B. WING _____	C 01/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEBERT NURSING HOME	180 LOG ROAD SMITHFIELD, RI 02917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 501	Continued From page 36 incident as referenced in F225 with S/S at the K level and resulting in the potential for serious harm. 3. As evidence by the facility failure to implement its own written policies and procedures that prohibit mistreatment, neglect, and abuse of residents as referenced in F226 with S/S at the K level and resulting in the potential for serious harm. 4. As evidenced by the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity as referenced in F241 with S/S at the K level and resulting in the potential for serious harm. Refer to F224, F225, F226 and F241	F 501	**F520** a) Although no residents were specifically mentioned in this particular tag, the references to 224, 225, 226 and 241 imply reference to residents 1, 2, 3 and 7. To that end our responses to those alleged deficiencies are incorporated herein including our disputing any suggestion that this alleged deficiency constituted immediate jeopardy as to residents 2 and 3, either at December 22, 2011 or at January 9, 2012. b) Although no residents were mentioned in this tag, we do recognize the importance of the matter and are responding timely and appropriately.	
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520	c) During the QA Committee Meeting held on 1/18/2012, all area of concern identified during survey were discussed in detail. All plans and actions already taken outlined to the committee. Goals for future actions established. Formal quarterly QA committee meetings will continue with all vendors and committee members as usual, however a monthly meeting will be held to ensure that problem identification, plan development, implementation and follow-up evaluation are consistently active. The Medical Director will be invited to all QA/QI meetings, but in lieu of attendance, all minutes forwarded and reviewed. d) The Administrator is responsible to ensure ongoing compliance with the QI Plan and QI/QA Program.	1/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 37 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the Quality Assurance (QA) meetings and staff interview, it was determined the facility failed to implement appropriate plans of action to correct identified quality deficiencies noted during the 7/19/2011 survey, relative to implementing their written policy and procedure for immediate reporting and the protection of a resident following an abuse allegation. Findings are as follows: Although the facility was previously cited on 7/19/2011 for failure to implement their written policy and procedure for immediate reporting and the protection of a resident following an abuse allegation, there lacked evidence the facility developed and implemented measurable goals and monitoring of compliance as part of the Quality Assurance Program. When questioned on 12/22/2011 at 9:30 AM, the Administrator and the Director of Nursing Services were unable to provide evidence the facility had developed and implemented a QA program appropriate to correct the above identified quality deficiencies.	F 520		

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F 520	Continued From page 38 Refer to: F224, 225 and 226. "You are hereby formally notified that where the above listed deficiencies also constitute non-compliance with applicable provisions of the 'Rules and Regulations for Licensing of Nursing Facilities' they are deficiencies under State Regulations and grounds for licensure sanctions."	F 520		

RI Department of Health

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	LTC00767	A. BUILDING _____ B. WING _____	C 01/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEBERT NURSING HOME	180 LOG ROAD SMITHFIELD, RI 02917

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M 320	ORGANIZATION and MANAGEMENT 18.2 Transfer Agreements, Contracts 18.2 Designated nursing facility personnel shall complete the " Continuity of Care " form ("Short Form") approved by the Department for each resident who is discharged to another health care facility, such as a hospital, or who is discharged home with follow-up home care required. Said form shall be provided to the receiving facility or agency prior to or upon transfer of the resident. This Requirement is not met as evidenced by: Based upon record review and staff interview it was determined the facility failed to complete the Department of Health approved continuity of care form for 2 of 2 residents who were discharged to another health care facility [ID#(s) 1 and 4]. Findings are as follows: 1. Record review revealed that resident ID #1 was discharged to the hospital on 11/13/2011. There lacked evidence of a state-approved "Continuity of Care" form. When interviewed on 12/22/2011 at 10:00 AM, the Director of Nurses (DNS) was unable to provide evidence the state-approved form was completed and provided to the hospital upon transfer of the resident. 2. Record review revealed that resident ID #4 was discharged to the hospital on 9/7/2011. There lacked evidence of a state-approved "Continuity of Care" form. When interviewed on 1/9/2012 at 2:45 PM, the DNS was unable to provide evidence the state-approved form was completed and provided	M 320	**M 320** a) Residents ID#1, 4 did not suffer any untoward affect. Resident ID#4 is no longer a resident at our facility. b) We have since reviewed other residents who may have had a continuity of care form generated and did not identify any further issues in this regard. c) During the nurses meeting held on 1/12/2012, the nursing staff was reeducated about the need to retain copies of the state approved Continuity of Care form created when transferring residents. Those nurses not in attendance at the meeting had one-on-one education with shift supervisors and/or staff development coordinator. d) supervisory staff will monitor retention of a copy of the form. These audit findings will be shared with the QI committee.	Revised 1/12/12

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: A. Barron RN — TITLE: Administrator — (X6) DATE: 1/25/12

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 320	Continued From page 1 to the hospital upon transfer of the resident.	M 320		