

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 000	INITIAL COMMENTS An abbreviated standard survey (KY16274) was conducted on May 11-12, 2011. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	Britthaven acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.	
F 225 SS=D	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	F 225	Britt haven's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kelly M. Goodwin* TITLE: _____ (X6) DATE: 05-03-2011

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 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all alleged violations of abuse were reported to the Administrator of the facility and other appropriate state agencies and failed to provide evidence that all alleged violations were thoroughly investigated for one of three sampled residents (resident #1). Resident #1 received three skin tears on April 6, 2011, as a result of an incident involving a staff member. However, the facility failed to report the incident to the Administrator and other appropriate state agencies, and further failed to provide evidence that a thorough investigation had been conducted.</p> <p>The findings include:</p> <p>Review of the facility's abuse policy, dated February 2009, revealed any employee who witnessed or suspected abuse had occurred would immediately report the alleged incident to their supervisor, who would immediately report the incident to the Administrator. The Administrator was responsible to ensure that complaints of abuse were investigated and reported to the appropriate state agencies.</p> <p>A review of resident #1's medical record revealed</p>	F 225	<p>ID Prefix Tag F225</p> <p>The investigation into the allegation of abuse for Resident #1 was reopened by the Administrator on April 12, 2011. C N A #1 was suspended pending the outcome of the investigation and returned to work on April 18, 2011 with no substantiation of abuse. C N A #1, C N A #2, LPN #1, and the social Worker were re interviewed by the DON and Administrator on April 14, 2011.</p> <p>Allegations of abuse for the past 6 months were reviewed by the administrator and the DON on May 27, 2011 using the facility's policy on Abuse, Neglect and Misappropriation as a guide to ensure all reported incidents had been investigated thoroughly per the policy & reported to the appropriate state agencies. No other issues were identified.</p> <p>The Administrator and DON were re-educated on June 3, 2011 by the Facility Registered Nursed Consultant on the facility's policy for conducting a through investigation including reporting</p>	

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F 225	<p>Continued From page 2</p> <p>the resident was admitted to the facility on June 15, 2010. The resident's diagnoses included Muscle Weakness, Difficulty Walking, Chronic Kidney Disease, and Altered Mental Status.</p> <p>A review of resident #1's quarterly Minimum Data Set (MDS) dated February 3, 2011, revealed the facility staff had assessed the resident to have no cognitive impairment.</p> <p>An interview conducted with the Administrator on May 11, 2011, at 11:00 a.m., revealed resident #1 had recently been hospitalized. Observation of resident #1 on May 11, 2011, at 12:56 p.m., was made in the hospital and an interview was conducted. Resident #1 stated the resident had received the skin tears on the left hand by a staff member, Certified Nurse Aide (CNA) #1. Resident #1 stated on April 6, 2011, at 7:30 p.m., he/she rolled in the wheelchair to the nurses' desk to get a cigarette box for a smoke break. Resident #1 stated he/she was holding the cigarette box and a staff member, CNA #2, asked resident #1 to give the CNA the cigarette box. Resident #1 stated he/she gave the box to CNA #2 and the CNA put the cigarette box back behind the nurses' desk. Resident #1 stated after a few minutes he/she then went back and got the box from the nurses' station and was holding the box again. Further interview revealed CNA #1 came from behind resident #1 and attempted to grab the cigarette box away from the resident. Resident #1 further stated that CNA #1 scratched resident #1 on the left hand in the process of taking the cigarette box from the resident. Resident #1 reportedly informed CNA #1 that the CNA had scratched him/her and, at that time, CNA #1 called resident #1 a "damn liar."</p>	F 225	<p>CNA</p> <p>suspected allegations of abuse to the appropriate State agencies. All facility staff was reeducated on 05-26-2011 by the DON and the staff Development Coordinator on the facility's policy on Abuse, Neglect and Misappropriation.</p> <p>The investigation of any allegations of abuse will be reviewed monthly by the Executive committee consisting of the Administrator, DON, Medical Director, MDS nurses, QI nurse, & Staff Development nurse to ensure the investigation has been conducted thoroughly per the facility policy to include reporting to the appropriate state agencies with further action taken as directed by the committee.</p> <p>June 25, 2011.</p>	05/25/11	

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F 225	<p>Continued From page 3</p> <p>Interview further revealed resident #1 informed the Social Worker (SW), CNA #1, CNA #2, and Licensed Practical Nurse (LPN) #1 that CNA #1 had scratched the resident and had caused the skin tears on the resident's left hand. Observation of resident #1's left hand on May 11, 2011, at 1:00 p.m., revealed bruising where the skin tears had been.</p> <p>Interview with CNA #1 on May 11, 2011, at 2:30 p.m., revealed the CNA had attempted to take the cigarette box away from resident #1 on April 6, 2011, at approximately 7:20 p.m., because the smoke break did not begin until 7:30 p.m. Further interview with CNA #1 revealed when the CNA went around resident #1's left side to take the cigarette box, resident #1 attempted to grab the CNA's wrist causing resident #1's hand to get caught in CNA #1's watch. CNA #1 further stated that resident #1 then twisted the watch around the resident's fingers causing the skin tears. CNA #1 stated that following the incident resident #1 did state that CNA #1 had scratched him/her. CNA #1 stated that after the incident the CNA went down the hall to get assistance for resident #1 related to his/her behaviors. CNA #1 further stated she met the Social Services Director (SSD) in the hall asked the SSD to come and assist with resident #1. Further interview revealed that CNA #1 did not observe the skin tears or blood until she came back down the hall with the SSD. Further interview revealed CNA #1 did not call resident #1 a "damn liar."</p> <p>Interview with the SSD on May 11, 2011, at 4:25 p.m., revealed the SSD had just gotten off work for the night and was leaving when CNA #1 came to the SSD and explained resident #1 was upset.</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>SSD stated that she went to resident #1 and observed the skin tears on the resident's left hand. Interview further revealed resident #1 had also informed the SSD that the skin tears were caused by CNA #1 scratching him/her. Further interview with the SSD revealed that although the SSD did not view the incident as abuse she reported the incident to Licensed Practical Nurse (LPN) #1.</p> <p>Interview with CNA #2 on May 11, 2011, at 4:45 p.m., revealed resident #1 had told CNA #2 that CNA #1 had scratched his/her hand. CNA #2 further stated that CNA #2 had informed LPN #1 of the allegation.</p> <p>Interview with LPN #1 on May 11, 2011, at 6:53 p.m., revealed the SSD and CNA #2 had informed the LPN on April 6, 2011, that resident #1 alleged CNA #1 had scratched him/her. LPN #1 further stated that an incident report was filled out. Interview further revealed CNA #1 and CNA #2 stated the skin tears were an accident and the SSD stated that after resident #1 had smoked a cigarette and "calmed down" the resident stated CNA #1 had not caused the skin tears on purpose, therefore, LPN #1 did not view the incident as an allegation of abuse.</p> <p>Interview with the Administrator and Director of Nursing (DON) on May 11, 2011, at 7:40 p.m., revealed it was their responsibility to investigate allegations of abuse. The Administrator stated that when a staff member witnessed, suspected, or someone alleged abuse, the staff member was to report the incident to the charge nurse who, in turn, was to notify the DON and the Administrator. The DON and Administrator further stated that,</p>	F 225		

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F 225	Continued From page 5	F 225		
F 282 SS=D	<p>although the incident had been investigated as abuse, the allegation of abuse by resident #1 had not been reported to the appropriate state agencies and the facility failed to provide evidence of an investigation of the alleged abuse.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide services in accordance with each resident's plan of care for one of three sampled residents (resident #1). On April 6, 2011, facility staff failed to approach the resident in a calm, patient manner, remove the resident from public area when the resident's behavior was disruptive/unacceptable, talk with the resident in a low pitch/calm voice to decrease/eliminate undesired behavior, provide diversional activities, and remove the resident to a quiet area while offering reassurance in accordance with the comprehensive care plan (CCP).</p> <p>The findings include:</p> <p>No policy on care plans was available.</p> <p>A review of resident #1's medical record revealed the resident was admitted to the facility on June 15, 2010, with diagnoses to include Muscle</p>	F 282	<p>ID Prefix Tag F282</p> <p>The Care Guide for resident # 1 has been updated to reflect the approaches identified on the comprehensive care plan for redirecting resident during periods of frustration, anxiety or agitation.</p> <p>An audit has been conducted on May 30, 2011 by the DON, MDS nurses, QI nurses & Staff Development nurse of all current residents to ensure that the approaches identified on each resident's comprehensive care plan has been identified on the residents care guide. These Care Guides are located in each resident's closet. Any approaches not listed on the care guide have been added. All new residents will have their individualized approaches identified on the Comprehensive Care Plan placed on their Care Guides. The Care Guides will</p>	

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F 282	<p>Continued From page 6</p> <p>Weakness, Difficulty Walking, Chronic Kidney Disease, and Altered Mental Status.</p> <p>A review of resident #1's quarterly Minimum Data Set dated February 3, 2011, revealed facility staff assessed resident #1 to have no cognitive impairment, no behaviors or rejection of care, and required extensive assistance of two staff members for activities of daily living.</p> <p>A review of resident #1's CCP dated March 24, 2011, revealed staff had assessed resident #1 to be easily annoyed and frustrated. A review of the care plan established for resident #1 related to activities of daily living revealed staff was to approach resident #1 in a calm and patient manner. Facility staff was also required to remove the resident from the public area and talk with the resident in a low-pitched calm voice to decrease undesirable behaviors. In addition, staff was required to remove the resident to a quiet area, while offering reassurance.</p> <p>Resident #1 stated on April 6, 2011, CNA #1 approached the resident from behind and took the cigarette box from him, which in turn caused skin tears to the left hand. Resident #1 also stated when the resident complained of CNA #1 scratching the resident CNA #1 called the resident a "damn liar."</p> <p>Interview with CNA #1 on May 11, 2011, at 2:30 p.m., revealed resident #1 was exhibiting behaviors on April 6, 2011, related to not being allowed to smoke. CNA #1 stated that she attempted to remove cigarettes from the resident's hands and during the attempt the resident sustained skin tears to the hand. CNA</p>	F 282	<p>be updated on going, as needed by the MDS nurses to reflect any change made on the Comprehensive Care plan. The cigarette box has been relocated to the locked medication room to prevent further resident access.</p> <p>All direct care staff have been re-educated on May 30, 2011 by the DON, & staff Development Coordinator on using the Resident Care Guides located in each resident's closet in order to provide the necessary interventions identified on the residents' comprehensive care plan for redirecting resident behaviors.</p> <p>The QI Coordinator and/or designee will conduct weekly audits on 10% of census to compare the resident's comprehensive care plan with the resident's care guide to ensure that all interventions identified for redirecting resident's behavior on the Comprehensive Care Plan are identified on the Care Guide. The Licensed Nursing Staff on all shifts will conduct daily rounds using a licensed nurse</p>

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F 282	Continued From page 7 #1 further stated that no other alternatives had been tried before reaching around resident #1 from the left and attempting to take the cigarette box from the resident. CNA #1 further stated at no time did she call resident #1 a "damn liar." Interview with CNA #2 on May 11, 2011, at 5:15 p.m., revealed resident #1 was exhibiting behaviors on April 6, 2011, such as hollering, cursing, and acting aggressive due to not being allowed to smoke at that time. Interview further revealed CNA #2 observed CNA #1 approach the resident from the left side and attempted to take a box of cigarettes out of the resident's hand. In addition, CNA #2 stated, based on observation, CNA #1 failed to attempt other measures to redirect the resident. CNA #2 further stated she did not hear CNA #1 call resident #1 a "damn liar."	F 282	rounds QI tool to ensure that staff are utilizing the residents care guide to provide the interventions identified to redirect resident behaviors and that the cigarette box remains in the locked medication room when not in use by staff. Any discrepancies will be addressed immediately and corrected as indicated. The results of the weekly audits by the QI nurse and the licensed nurse rounds tools will be reviewed with the Administrator and DON in the weekly QI committee meeting with further action taken as directed. Any trends & the accompanying actions will be reviewed monthly by the Executive QI committee, consisting of the Administrator, DON, Medical Director, QI nurse, Staff Development Nurse and MDS nurses with further retraining as necessary. June 25, 2011	6/25/11	